

**The Influences of Being an Adopted Person on the Psychotherapeutic Relationship
from an Object Relations Perspective:**

A modified systematic literature review with clinical illustrations.

Jennifer L. Hylton

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Primary Supervisor: Andrew Duncan

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: _____ Date: _____

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Ethics Approval

Ethical approval for this dissertation has been obtained from Auckland University of Technology Ethics Committee (AUTEK) on 27 April 2004 (ethics application number 02/33).

Abstract

While there has been much debate about the inherent risks of adoption and the proposed psychosocial impacts, it is generally agreed that adoption places the adopted person at risk of some psychological sequelae and that adoption is a lifelong process.

Furthermore, it has been reported that adoptees are overrepresented in mental health settings. It therefore behoves therapists to familiarise themselves with the implications of adoption for the therapeutic relationship.

The purpose of this dissertation is twofold: firstly, to inform the non-adoptee psychotherapist who will be treating adopted people of the psychosocial impacts of adoption, and the consequences of these for the therapeutic relationship from an object relations perspective; secondly, to invite the adoptee therapist to consider the impacts of this status working with adoptee clients, particularly relating to issues of identification and over-identification.

A systematic review of the relevant literature was conducted to answer the research question – what are the influences of being an adopted person on the therapeutic relationship? Additionally, clinical work with an adopted client was drawn on to illustrate the concepts being discussed. Finally, the author's personal experience as an adopted person and client was periodically used to enhance the discussion.

It was found that adoption is a significant experience of loss which is likely to impact on the person's developing self-representation, identity formation, attachment capacity, and object relations. The existence and degree of this impact then has consequences for the therapeutic relationship, most notably in terms of binary or hole-object transference, fears of abandonment by the therapist, adoption related fantasies, and countertransference fears of letting the client down.

It is further proposed that while the therapist who is an adopted person is uniquely positioned to identify with some of the experience of the adoptee client, there are also unique risks to the relationship because of this shared experience. While no research was located in this area, it was speculated that responsibility lies with the therapist to do significant personal processing of adoption related issues to ensure that the benefits of identification do not become the disadvantages of over-identification.

Chapter One

Introduction

This topic is of interest to me because of my personal experience with adoption. It became an active psychotherapeutic issue once I decided to search for my birth mother and I became more interested in the experience of other adoptees.

Before this, I had understood that being an adoptee was likely to have impacted on my self-esteem and created sensitivity to feelings of abandonment. I had a somewhat superficial, emotionally disconnected idea of the impact of adoption and little knowledge of the unique issues my adoptee status brought to my own therapy.

As a trainee psychotherapist, I worked with one adopted client. Although the therapy continued for more than a year, I felt there was something missing in the alliance, and I experienced the work and our relationship as somewhat superficial. Adoption issues were explored, but not addressed in depth. After the work finished and I had come to understand adoption better through a deepening relationship with my birth mother, I realised I could have helped this client a lot more. In hindsight, I can see that my lack of knowledge at the time limited the gains from therapy for my client, and perhaps even the degree to which we were able to form an alliance.

The Context in Aotearoa

Adoption is an issue that every therapist is likely to encounter in his or her professional life. This is particularly so in Aotearoa New Zealand, which has had the highest number of adoptions per head of population in the Western world (Iwanek, 1997). The peak was reached in the years of closed stranger adoption from 1955 to 1986. In 1969, one child was adopted per every 7.2 live births (Griffith, 1997).

In this country, “whangai” is a unique form of adoption among tangata whenua (the indigenous people) which occurs within the extended family (McRae & Nikora, 2006). Exploration of the psychotherapeutic implications of this uniquely Maori process is outside the scope of this study.

Honouring my Treaty Obligations

This dissertation acknowledges the principles of partnership, protection and participation elaborated in the Treaty of Waitangi (Durie, 1998). While not directly contributing toward a partnership with Maori, some groundwork is laid for future research to be conducted on the therapeutic relationship with adopted people from a Maori perspective.

The principle of protection is acknowledged by recognising the limitations that the author's Pakeha¹ cultural heritage places on her authority to provide a voice for Maori in this study. This dissertation is written from a Pakeha worldview and focuses on work with Pakeha adopted clients.

Finally, the principle of participation has been honoured through the sharing of stories and aroha with a colleague who conveyed to me her experience of what it means to be Maori, adopted within Pakeha adoption practices, and the importance of knowledge of the foundations of Maori health when working therapeutically with Maori adopted under non-traditional practices. A thorough consideration of these issues is outside the scope of this dissertation, but a beginning discussion has been included in the appendix.

The Psychosocial Impacts of Adoption

Most research agrees that adoptees are over-represented in mental health settings (Brodzinsky, 1993; Ingersoll, as cited in Nickman, 2005). The reasons for this will be elucidated in this dissertation. The research indicates that adoptees are most likely to encounter difficulties and enter therapy as they reach normal developmental milestones such as marriage, the birth of a first child, or death of a loved one. Due to a tendency to reassess their relationships and their identities at these times, the adoption issue is reignited (Brodzinsky, Schechter & Henig, 1992). There is now a well established understanding that adoption cannot be meaningfully understood as a one-off event or moment, and needs to be seen as a process, whose meaning is re-worked throughout the life cycle (Rosenberg, 1992). It is therefore important that therapists understand when and how adoption is likely to impact on clients.

¹ In this context, Pakeha is taken to mean all non-Maori citizens of Aotearoa.

There is some debate in the literature about the nature and degree to which adoption presents a special case, worthy of attention. At one end of the spectrum, some see adoption, and all those closely involved in it, as pathological, and recommend its abolition (Feder, 1974; Ludbrook, 1997). At the other extreme, some see it as the ‘ideal’ solution to a common societal problem, and see the emotional and psychological consequences as negligible, or largely repairable with a supportive adoptive environment (Fisher, 2001; Kadushin, 1980).

This dissertation will examine the literature on this debate and present summary conclusions. I will establish that many people do have clinical problems resulting from adoption and I will explore the nature of some of these problems and consider how they affect psychotherapy with the adopted person.

Psychotherapy with the Adopted Person

Having confirmed adoption as a therapeutic issue worthy of further examination, the literature on the dynamics one might expect to encounter in the therapeutic setting will be explored and critiqued. It is proposed that special aspects of transference and countertransference exist in therapeutic work with adoptees (Zuckerman & Buchsbaum, 2000). Therefore, the main aspects of the relationship this dissertation will focus on are the countertransference feelings the therapist experiences, and what these might suggest about who the therapist is representing for the client in the moment, that is, transference (Clarkson, 2003). Also considered will be the role of fantasy in the relationship, and the interaction of therapy with search and reunion.

The literature in the adoption area is rich with case studies with both adults and children. However, it is noteworthy that few of these studies go into great detail about therapist client dynamics, particularly therapist countertransference. This review will examine what literature there is in this area. It will also examine material from both these client groups, where they coincide on the therapeutic modality of object relations. Interestingly, no research was found on the effects of open adoption on the therapeutic relationship. For reasons of space I will not be speculating about these effects.

Object relations are “the inner residues of past relationships that shape an individual’s current interactions with people” (St Clair, 1996, p. 1). This theory is

particularly relevant to work with adoptees because of the complexities of having two sets of parents, whether one set (the biological) exists in the fantasy or real life of the client. This review will explore the adopted person's object relations as they occur in the therapeutic relationship. I will then critique the use of object relations as the modality of choice and explore other alternatives.

The Adoptee's Voice

Reviews of the literature on adoption note that, "the absence of the adoptee's voice in this debate is surprising" (Brodzinsky, 1993, p. 162). I agree with this, and believe it would be valuable to have the adoptee's voice brought directly into the literature. I will begin to redress this imbalance by bringing in my own voice as an adoptee. As a Pakeha New Zealander, born in the early 1970s, my experience of adoption was of closed stranger, intra-racial adoption. This provides a specific context for the adoption experience I bring to this discourse.

There is certainly very little professional disclosure of authors' personal history with, or explanation of, their interest in adoption. Throughout this review, clinical illustrations of my therapeutic work with one adoptee and from my own experience as a client will be used to bring the literature to life, and to identify ways in which therapist knowledge in this area may benefit the healing process for clients.

In examining the adoption literature, there is a surprising lack of material about the therapist as adoptee and how this might impact on the relationship with adopted clients. This dissertation will add to this growing body of research some speculations about such dynamics, extrapolated from the clinical and theoretical material reviewed as well as personal experience.

The outline of the dissertation will be as follows:

Chapter Two: Describes the process of conducting the systematic literature review, including choices about inclusion and exclusion criteria.

- Chapter Three: Defines relevant terms and describes distinctions within adoption that contribute to the adopted person's object relations.
- Chapter Four: Establishes that there are challenges as a result of adoption. Summarises and critiques the nature of these problems:
- Grief and loss
 - Impaired attachment
 - Challenges to Oedipal resolution
 - Difficulties with the integration of love and hate
 - Challenges to identity formation
 - Unique self and object representations
- Chapter Five: Summarises and critiques the material on the impact of an adopted status on the therapeutic relationship. This covers:
- Therapeutic goals and assessment considerations
 - Unique aspects of transference and countertransference
 - Adoptees' fantasies as defence mechanisms
 - Complications due to the degree of knowledge of biological parents
 - Search and reunion implications
 - Termination issues
- Chapter Six: Extrapolates ideas about the impact of therapist as adoptee on the therapeutic relationship.

Chapter Seven: Discusses the findings and their clinical implications.

Chapter Two

Methodology

This chapter details the research method used to answer the question: What are the influences of being an adopted person on the psychotherapeutic relationship? It describes the approach undertaken in conducting the research, and outlines the decisions made in narrowing down the search for literature. The process for addressing ethical issues related to this research is also elaborated.

Methodological Approach

In the positivist paradigm, emphasis is placed on the importance of systematic observation, and objectivity (Grant & Giddings, 2002). The primary method used in this research is the systematic literature review. “Systematic literature reviews, including meta-analyses, are invaluable scientific activities” (Mulrow & Cook, 1998, p. ix). They assist in managing and summarising huge amounts of research data to answer important clinical questions.

Systematic reviews help determine whether findings across studies on a particular subject are reliable and consistent, and may be generalised to broader populations. They also assist the identification of gaps in the literature to support the development of further research.

The classic systematic literature review focuses on gathering quantitative data. Given that the large majority of literature in the psychotherapy field is based on case study and theory (Loewenthal & Winter, 2006), a classical approach to the review is not possible. This systematic literature review is therefore modified by its emphasis on qualitative data. “Qualitative methods aim to make sense of, or interpret, phenomena in

terms of the meanings people bring to them” (Greenalgh & Taylor, 1997, p. 740). ‘Data’ within this type of research tends to consist of observations and interviews. This type of review is known as a meta-synthesis: “An interpretive integration of qualitative findings that synergistically and inclusively crafts together findings across the target domain and facilitates knowledge development” (Thorne, Jensen, Kearney, Noblit & Sandelowski, 2004, p. 1358).

An additional variation from the pure systematic literature review is the inclusion of clinical vignettes and personal narrative about my therapeutic experience as an adopted person. These are used to illustrate the unique issues that arise with adopted people, to examine and critique interventions used to support ‘working through’ these issues and to begin to bring in the voices of adoptees themselves.

Levels of Evidence of Studies in the Review

Within both quantitative and qualitative research, a range of studies may be conducted. These various types of studies have been categorised as meeting a certain ‘level’ of evidence. For qualitative evidence, the most highly regarded findings are those offering large degrees of complexity and discovery, often found in methods such as ethnography, phenomenology and grounded theory (Kearney, 2001). The least highly regarded findings are those restricted by ‘a priori’ frameworks. That is, the application of a predetermined set of ideas without consideration of new insights and revisions that may be made throughout the research process.

The most highly regarded quantitative studies, meeting the highest level of evidence, are systematic reviews of randomised clinical trials, and the studies deemed as having the least credibility are those using opinion and description (Sackett, 2005).

Studies of adoption.

In addressing the dissertation question, two distinct bodies of research were examined. The first relates to the question of whether adoptees can be recognised as a unique group of people, with distinctive, predictable psychosocial issues. The second

relates to the question of how such clients present in psychotherapy and the unique dynamics they bring to the relationship.

There are three main sources of evidence identifiable in the debate about whether adoptees are at risk of developing psychosocial problems: (1) epidemiological studies of the incidence and prevalence of adoptees in patient or special education populations, (2) quantitative clinical studies examining the nature of presenting symptomatology in adopted and non-adopted people, and (3) quantitative studies examining the personality and behavioural characteristics and patterns of adjustment of non-adoptees and adoptees in community samples (Brodzinsky, 1993). These all come from the quantitative tradition and meet the criteria for high levels of evidence (Sackett, 2005).

In regard to psychotherapy with adoptees, a lot of the material comes from pure theory and case studies. Authors provide tentative conclusions based on work with a large number of clients, or a few clients, and sometimes from work with one adopted client. Such case studies have been invaluable in helping me understand in depth the dynamics of adoption.

From a positivist paradigm, this evidence is limited as case studies provide in depth subjective information about unique situations and people, and cannot be generalised to the broader population, in this case, adopted persons (Grant & Giddings, 2002). However, within the qualitative framework, case studies are considered to provide a moderate level of evidence and in this context it is clear that the strengths of case study material outweigh the weaknesses. At the current stage in the study of therapeutic work with adoptees, what is most important is developing an understanding of the dynamics of adoption. At a later stage more quantitative research will provide more definitive answers. Therefore, research based on case study, while having its limitations also has its place in the contribution to effective psychotherapeutic practice.

Ethical Issues

The most significant ethical issue for this dissertation is the possibility of the client reading it, recognising herself and feeling that her confidentiality has been breached. To allow for this possibility, I have sufficiently disguised the material to be

unrecognisable to the client. Also, the client has given permission for her clinical material to be included in this review (see Participant Information Sheet and Consent Forms in Appendix B).

To protect the client's anonymity in the clinical material, a pseudonym is used, and any identifying characteristics and names of other people or workplaces are omitted.

Ethical approval has been obtained from Auckland University of Technology Ethics Committee (AUTEK) on 27 April 2004 (Ethics Application number 02/33).

Search Criteria and Strategy

Given the vast literature on adoption, it was necessary to clearly demarcate the parameters of this review. Inclusion and exclusion criteria are discussed below.

Evidence related to early and late placed adoptees whose presenting problems were confounded by pre-placement abuse were excluded. An additional restriction of this study is the focus on the Pakeha practice of adoption. I have therefore excluded material about adoptees experiencing the whangai adoption process (McRae & Nikora, 2006), or indeed other cultural variations of adoption.

Studies of open and closed adoption are included, although in the main, studies relate to closed adoption. The numbers of babies and children being adopted from other countries has increased relative to within country adoptions in the past few decades in New Zealand (New Zealand Official Yearbook, 2006), and much has been written recently about the experiences of such parents and children (Ahn-Redding & Simon, 2007; Alperson, 1997; Armstrong & Slaytor, 2001; Gaber & Aldridge, 1994; Kennedy, 2003; Pertman, 2000; Stace, 1997). This area was deemed worthy of separate exploration. I have therefore, limited the review to intra-racial adoption with the exception of Maori adoption by Pakeha and excluded research on inter-country adoption because these involve other dynamics.

Also excluded, was group and family psychotherapy material as this was deemed outside the scope of this research. Finally, I excluded biographies of adoptees unless they had stories of therapy and I also excluded children's books on adoption.

While the focus of the review is on the influences of adoption from an object relations perspective, material exploring the interpersonal dynamics of adoptees from alternative modalities was included to assist in the critique process. Also, evidence from both psychoanalysis and psychotherapy with adoptees was gathered.

During the search process I discovered one key author, and so conducted a search on this author to determine whether there were any additional articles that might be relevant. Finally, articles written in languages other than English were excluded.

Literature was located from the following databases and resources:

PsycINFO: was used because it is the largest storehouse of psychological literature available.

PEP (Psychoanalytic Electronic Publishing): was valuable for locating literature including object relations, as this is a psychoanalytic concept.

Auckland University of Technology Library Catalogue

Auckland Public Library Catalogue

Reference Lists: As literature located from databases and catalogues was examined, reference lists were perused; any articles that appeared to fit the topic were also collected.

Data Collection

The following tables show the search terms used to search for literature within the identified databases and catalogues. The tables also display the number of results found using these terms, and the more refined number of items that were relevant to the research question.

PsycINFO

This database is presented first, as most of the literature was located here. The initial search, which used a truncation of the word adoption, to include all variants of the word, resulted in too many items. Therefore, more specific searches were conducted.

Search Terms	Results	Relevant
Psychotherapy and adopt\$	893	Too broad
Psychotherapy and adopted	399	40
Psychotherapy and adopted children	68	22
Psychotherapy and adoptive	77	8
Psychotherapy and adoptees	29	15
Psychotherapy and child adoption	4	2
Adopt\$ and object relations	93	14
Brodzinsky	45	8

Psychotherapy and adopt\$ with 893 results is too many to examine within the scope of this dissertation; however it breaks down into the four combinations above. The remaining several hundred results contain material related to adoption, which includes the broad definition of adoption as ‘taking on’. Therefore, to identify material specific to the topic it was necessary to add the word ‘child’ in the search criteria.

PEP

Within this database, because it is psychoanalytic, the terms psychoanalytic or psychotherapeutic were redundant.

Search Terms	Results	Relevant
Adoptees	41	20
Adoption	20	13
Adoptive	3	1
Adopted	16	9

Auckland Public Library

After a preliminary search using adoption and psychotherapy found only 1 result with this combination of terms, the search was broadened to include variations of the root 'adopt'.

Search Terms	Results	Relevant
Adoption and Psychotherapy	1	1
Adoption	361	11
Adoptive	90	4
Adopted	601	4
Adoptees	99	11

AUT Library

Search Terms	Results	Relevant
Adoption and Psychotherapy	3	2 (Too narrow)
Adoption	229	16
Adopted	150	7
Adoptive	22	12
Adoptees	5	4

Summary

The PsycINFO database provided the largest pool of literature related to the topic. In the remaining databases, specific searches attempting to locate literature on psychotherapy with adoptees did not produce many results, and more general searches

related to the subject of adoption were conducted. Overall, sufficient research material was found to be able to answer the research question.

Chapter Three

Definitions and Distinctions within Adoption

This chapter provides definitions of terms related to adoption and object relations, and outlines the distinctions within adoption that result in differing consequences for the adopted person's object relations. I will first define object relations, and its connection to a person's adoptee status. Secondly, I will explore key distinctions within adoption that impact on the adopted person's object relations such as the type of adoption, the age at placement, the timing and nature of adoption disclosure and reunion.

Object Relations

Object relations are the name we give the internalized storehouse of memories of early relationships between the self and significant others. These memories then influence one's feelings and actions when relating to others (Priel, Kantor & Besser, 2000; St Clair, 1996).

Hodges (1990) identifies that in adoption, the therapist is dealing with an additional set of inner representations – those of the biological parents. These are a different kind of representation as they are symbolic of an object of which the child, placed as an infant, has little experience.

Object relations theory and its related model of practice therefore offers a useful framework for understanding the complexities of the internal world of the adopted person, given the challenges of integrating two sets of parents.

Adoption

“There is no universal or singular view of adoption” (Trowell & Etchegoyen, 2002, p. 204). However Grotevant & McRoy (1998) propose that in Western culture, the traditional mid-20th century definition of adoption is:

A social and legal process whereby a parent-child relationship is established between persons not so related by birth. By this means, a child born to one set of parents becomes, legally and socially, the child of other parents, a member of another family, and assumes the same rights and duties as those that obtain between children and their biological parents. (Costin, 1972, p. 359)

This definition reflects the ‘complete break’ concept of adoption that predominated in America in this era. Definitions and understandings of adoption therefore need to take into account the historical and cultural context in which it occurred.

A more current definition of adoption is provided by Reitz and Watson (1992):

A means of providing some children with security and meeting their developmental needs by legally transferring ongoing parental responsibilities from their birth parents to their adoptive parents; recognising that in so doing we have created a new kinship network that forever links those two families together through the child, who is shared by both. (p. 11)

In Aotearoa, people adopted between 1955 and 1985 were subject to a different experience (and therefore definition) of adoption from those born either side of this period. Under the first piece of adoption legislation in this country, The Adoption of Children Act 1881, there was no secrecy and children were given a hyphenated surname combining their birth and adoptive parents’ names (Gillard-Glass & England, 2002). Then in 1955, as a result of the Adoption Act, court records were sealed, the child took on the surname of the adoptive parents and adoption orders deemed adopted children “to be children of adoptive parents as if born to them in lawful wedlock” (Gillard-Glass & England, 2002, p. 31). The reasons for this historic change are beyond the scope of this dissertation.

The emphasis in the social discourse of adoption in Aotearoa has historically been on the gains, avoiding or minimising the losses. This reflects societal views of adoption in the latter half of the 20th century as a remedy to the problems of all parties involved, and a denial of the pain and on-going difficulties arising from such a disruption to the natural process of mother-child bonding and attachment (Else, 1991).

Object Relations in the Context of Adoption

Adopted children develop internal representations of both the adoptive parents they know, and the biological parents who in the case of closed adoption, are unknown (Hodges, 1990). She proposes that the adopted child's self-representation develops "in interaction with both sets of parental representations" (p. 62).

In constructing the representations of unknown biological parents, the adoptee must draw on what little information they have. With no information, "fantasies are constructed to attempt to organise an internal picture of the person's heritage and biological identity" (Freeman & Freund, 1998, p. 26).

Splitting is an object relations term of relevance to adoptees. Fairbairn (1944/1954a) argued that "the child attempts to control the troublesome object in its world by mentally splitting the object into good and bad aspects and then taking in or internalizing the bad aspect" (p. 56). For the adopted person with two sets of parental objects, there is often a tendency to split biological and adoptive parents in such a way that one set of parents hold all the good aspects, and the other hold all the bad (Brodzinsky, Smith & Brodzinsky, 1998). This will be elaborated in chapters four and five.

Distinctions within Adoption that Contribute to the Adoptee's Object Relations

Open adoption or closed stranger adoption.

In Closed Stranger Adoption (Else, 1991), the child is separated from its birth parents as if there need be no future relationship, and taken in by strangers with the expectation that a bond will form equivalent to that between an infant and biological parents. The child is given a new name, a new birth certificate is issued, and the records containing information about the adoptee's biological parents are sealed. In Aotearoa, this form of adoption predominated between the 1950's and the 1980's, resulting in approximately 100,000 adopted children (born in Aotearoa) whose birth records were sealed (Griffiths, 1997).

With the introduction of the Adult Adoption Information Act of 1985, adopted persons have been allowed access to their original birth certificates², as long as there is no veto in place against obtaining this information. The Act requires that people being issued this information open it in the presence of a counsellor. In the 2005/2006³ period alone, 717 New Zealand citizens were issued original birth certificates (Griffiths, 1997). This information has consequences not only for the adopted person, but for their adoptive parents, birth parents, siblings, and their own partners and children. Thus, the numbers of people affected by adoption are significant.

Open adoptions are “based on an agreement, reached at the time of a placement, that there will be some form of continuing contact between birth parents, adoptive parents, and the adopted child” (Rockel & Ryburn, 1988, p. 161).

Since the beginning of the 1980’s, open adoption in New Zealand has become standard practice. New Zealand is the only country in the western world where adoptions of this kind occur as a matter of course through both private and government agencies (Fowler, 1998).

Age at placement.

Of all the postnatal risk factors in adoption, perhaps none has been explored as fully as age at placement. Numerous authors have argued that the later the child is placed, the greater the chance of postplacement adjustment difficulties (Bohman, as cited in Brodzinsky, 1993; Hersov, 1990).

There is some disagreement about what constitutes “late” placement. Nickman (1985) distinguishes late adopted children as those adopted after 6 months of age. This is the period when the infant begins to distinguish self and others (Hamilton 1990). Infant research using the Strange Situation has found that children placed after 6 months

² “Original birth certificate”, in relation to any person, means a certificate under section 38 of the Births and Deaths Registration Act 1951 or the original entry of that person's birth, endorsed on its face with the words “ISSUED FOR THE PURPOSES OF THE ADULT ADOPTION INFORMATION ACT 1985”; and includes any such certificate from which there have been omitted, in accordance with this Act, any details relating to either or both of that person's birth parents.

³ Figures are reported for the fiscal year.

of age often display attachment related difficulties (Yarrow & Goodwin, 1973; Yarrow, Goodwin, Manheimer & Milowe, 1973).

Frankel (1991) suggests that since bonding occurs before age 2 or 3, children adopted after this time will have a powerful investment in biological parents. Meissner (as cited in Frankel, 1991) suggests these findings are consistent with the position that “the early reciprocal relationship with parents forms the basis for the most basic and enduring self-object representations, and that these are fundamental in the progressive development of object and self constancy” (p. 8).

Irrespective of a lack of agreement regarding the definition of late placement, it is generally recognised that some of the critical factors underlying increased psychological risk are those specific experiences the child encounters prior to adoption placement (Verhulst, Althaus, & Versluis-den Bieman, as cited in Brodzinsky, 1993).

Later placed children are more likely to have experienced adoption disruption, that is, where the adoptive parents discontinue the adoption (Brodzinsky, 1998), a greater number of foster care placements (Wieder, 1977), and are more likely also to have been abused (Brodzinsky et al., 1998); all issues which “becloud the impact of the adoption story itself” (Wieder, 1977, p. 1).

It is clear therefore, that the unique situation of the adopted person, including the age at which they were placed, and their preplacement history is likely to have contributed to the formation of their object relations.

The timing and nature of disclosure.

Additionally, the issue of when and how to tell the child their adoption story is one that has created much disagreement among experts over the years of Closed Stranger Adoption.

In New Zealand in 1957, while the Child Welfare organisation declared their intention to ‘issue a printed memorandum’ for adoptive parents on how to tell, this never happened. Press stories on adoption provided their own examples of how to deal with telling. One of the most common stories was the ‘Chosen Baby Story’ (Else, 1991), which said:

Mummy and Daddy had gone to the nursery to look at all the babies. And they had looked and looked and then they came upon this little baby in the bassinet.....And as they were looking the baby smiled up at them and laughed.....And Mummy said to Daddy, 'Oh, let's adopt this one.' And that was how Mummy and Daddy brought [you] home. (p. 144)

Such stories emphasise the adopted child being wanted; neglecting the unspoken reality that before the child was wanted, he or she was perhaps unwanted (Brinich, 1995).

Wieder, in describing his psychoanalyses of three such adoptees (entering analysis at ages 9, 17 and 27 respectively) who were told of their adoptive status under three years of age, reports "after the disclosure, the children's behaviour, thought contents, and relationships showed dramatic changes which could then objectively differentiate them from blood-kin children" (Wieder, 1977a, as cited in Wieder, 1978, p. 2). Following disclosure children displayed anxiety, confusion, shame and rage.

Wieder claimed that the child's limited ability to understand the implications of adoption resulted in long term impacts on the adopted person's personality development (Wieder, 1978). However, this is retrospective reporting based on one case study (with a 27-year-old) which cannot be relied on as credible evidence of long term outcomes.

He also proposed that the disclosure of adoption at an age when the distinction between fantasy and reality is blurred "endowed phase-specific fantasies of loss of object and love with a sense of actuality" (Wieder, 1978, p. 2). This notion is supported by other clinicians (Freeman & Freund, 1998; Nickman, 1985; Novak, 2004).

It is further suggested that the disclosure of adoption may interfere with the child's resolution of the oedipal conflict (Brodzinsky, 1987; Gilmore, 1995). More specifically that oedipal anxiety is increased in the adoptive child because of the reduced taboo of the fantasied rivalry. Gilmore (1995) claims that the adopted girl child's wish for a baby presents a special case in that "the little girl's potential to outdo her mother has a future reality that may be guiltily experienced as a source of the mother's ongoing suffering" (p. 9). These contentions remain speculative however, as no empirical research exists.

Several researchers have therefore suggested that adoptive parents should delay the ‘telling’ process until after this developmental period. One author advocates waiting until “the child is seven or eight when logical thinking has superseded immersion in fantasy and he is past the oedipal phase” (Fisher, 2001, p.1). Another proposes that “it appears that the longer the communication can be put off the better” (Wieder, 1978, p. 4).

Counter to this, more recent authors on this subject have suggested that “clinical wisdom supports telling the story even before the child can really comprehend its significance, in order to avoid even a semblance of secrecy or shame about the issue of adoption” (Rampage, Eovaldi, Ma, & Weigel-Foy, 2003, p. 216).

Nickman (1985) argues that the focus is less on finding ‘the moment to tell’, but rather to be sensitive through their child’s lifetime to “moments when the multifarious meanings of being adopted (emotional, fantasied and practical) impinge on the child’s life and require explanation, clarification, support or direction” (p. 15).

In line with Nickman’s thinking, the implications for therapy with the adopted person are that the timing and nature of adoption disclosure and the meaning the child made of it, were important variables in the development of their object relations and should be considered in therapeutic assessment and working through.

Search and Reunion

Of significance for the therapist working with the adopted person, is the meaning search has for the client. In what ways is the search internal and in what ways is it external? How much of the search operates in fantasy and how much in reality? The answers to these questions will be linked to the adopted person’s object relations and therefore will influence the evolving therapeutic relationship.

Sorosky, Baran & Pannor (1976) describe their experience of adoptees who are perpetual searchers, never quite reaching a reunion. They suggest that “the search itself (along with the associated fantasies) is the significant process serving to hold their personalities together” (p. 902). They propose that rather than risk being disillusioned, these people prefer to cling to their fantasies.

Some therapists believe that adoption (and abandonment) healing and integration can only occur through the process of search. Lifton (1994) says, "Healing begins when adoptees take control of their lives by making the decision to search" (p. 128). Bach (1998) supports this view and proposes that "the process of the search is as important as the reunion outcome" (p. 54).

In Aotearoa, the Adult Adoption Information Act 1985 resulted in about 20,000 reunions of adopted persons with their birth parents and other relatives (Griffith, 1998). In a study of American adoptees, Sorosky and associates (1976) found that for 50 adults who had undergone reunions, the median age at time of reunion was 31.

These authors found that the onset of the adoptees' search seemed to have been catalysed by such factors as: marriage, pregnancy, the birth of a child, death of an adoptive parent, and genealogical concerns (Sorosky, Baran & Pannor, 1975).

Again of relevance for the therapist, is knowledge of the client's stage of reunion both internally and externally. Is the client in reunion, in fantasy of reunion having gained identifying information, or satisfied with knowing their origins and not desiring reunion at all? There are differing implications for the therapeutic relationship with the person depending on where they are in this process.

Summary

Each of these distinctions within adoption has implications for the resulting object relations of the adopted person, and therefore his or her interpersonal relations. Working with the adopted client, the therapist will need to be familiar with these distinctions and aspects of adoption and their likely impacts as the therapeutic relationship progresses. These will be discussed further in chapter five.

The next chapter will briefly review the literature on the psychosocial impacts of adoption on the adopted person, to further inform the therapist of the unique profile the adopted person brings to the relationship.

Chapter Four

The Psychosocial Impacts of Adoption

This chapter will open with a brief discussion of whether adoption does create a psychological risk for the adopted person. A description is then provided of the expectable self and object representations of the adopted person as a consequence of being separated from biological parents and being raised by a new set of caregivers. Finally, a brief overview of the psychosocial issues for adoptees is presented including grief and loss, impaired attachment, challenges to identity formation and the development of self esteem and difficulties with the integration of love and hate.

Does Adoption Create Psychological Risk for the Adopted Person?

While the majority of adopted children are within normal limits for psychological development, it is acknowledged that as a group, “they show a higher incidence of behavioural, emotional, and academic problems than their nonadopted peers” (Brodzinsky, 1993, p. 43). Many studies have reported greater referral rates for adoptees to psychological services than their non-adopted counterparts. Dresser, (as cited in Jones, 1997) identified that adopted children were “perhaps twice as likely to present with psychiatric problems in childhood or later in life than are non-adopted children” (p. 64).

Wierzbicki (1993) conducted a meta-analysis of 66 published studies comparing the psychological adjustment of adoptees with non-adoptees. The main finding was that “adoptees had significantly higher levels of maladjustment” (p. 447).

Some researchers say the effects of adoption are minimal and can be ameliorated. For example, Fisher (2001) in reviewing longitudinal studies of adoption outcomes reported on the Fergusson, Lynskey and Horwood (1995) study of 1265 children (41 of which were adopted). She commented that “difficulties in adolescence were able to be resolved with tutoring, counselling, and parental support” (p. 152). At retesting in young adulthood, adoptees and biological controls showed no significant differences in their psychological functioning on a range of measures”.

However she is misquoting the study. Fergusson and associates report that adoptees show significantly more externalising behaviours than non-adoptees from two parent families. Secondly, Fisher claims these problems are ameliorated by tutoring and parental support however there is no mention of this in the Fergusson study. Consequently the evidence is very clear that adoption does create a psychological risk for the adopted person (Brodzinsky, 1990; Brodzinsky & Pinderhughes, 2002).

The Adopted Person's Object and Self-Representations

Object representations.

The adoptee is in the unique position of having two sets of parents. With open adoption, some information about biological parents will be known and will contribute to the formation of object representations. For the person adopted under closed adoption protocols, the representations of these parents are based on what little information, if any, has been obtained.

Rustin (1990) notes there is no opportunity for the adopted child (under closed adoption) to readjust his or her early perceptions or fantasies of biological parents through actual interaction. This leaves these internal representations partial and unmodified, either idealised or devalued.

At times many children fantasise about being adopted. They question whether their parents are actually their parents and imagine other usually more idealised ones (Harper, 1984). Freud (as cited in Brinich, 1995) explained that these adoption fantasies allow children to reclaim early images of parents when they are feeling disillusioned with the parents they have. Fantasies of adoption facilitate the concurrent expression of love and hate and "allow us to direct these feelings towards different aspects of our parents – these aspects being represented by the two sets of parents within the family romance" (p. 9).

For the adopted child, the family romance fantasy has a startling reality. Another set of parents does indeed exist. However, the fantasised parents of adoptees often take on a more negatively coloured perception. At the extreme, they may be seen as 'depraved and destitute'.

Priel, Kantor & Bessor (2000) studied the maternal representations of a non clinical sample of adoptees. A main finding was that adoptees' maternal representations were significantly less caring and more punitive than non-adoptees' maternal representations. This was the case for representations of birth and adoptive mothers. They concluded that "having been given up may add a basic negative dimension to adoptees' world of representations" (p. 9). Importantly, Deeg (1989) proposes that identification with such negatively imbued object representations can create negatively-coloured self-representations.

Furthermore, Priel and associates found an association between latency adoptees' splitting of two maternal representations and externalising behaviours which "corroborates basic psychoanalytic assumptions about the importance of an integrated internal world of representations for normal development, as well as the relations between splitting and aggressive behaviour" (p. 143).

Self-representation.

The knowledge of, and the fantasies around, having been given up, feed into the development of the adopted person's object and self-representations. Hodges (1990) suggests that the fantasy of not being wanted by the birth mother creates a self-representation as unwanted which extends into being unwanted. There is a great deal of support for this notion (Brinich 1990, 1995; Kernberg 1986-1986; Nickman 1985; Sherick 1983; Wieder 1978).

Another proposed outcome of adoption for the adoptee's self-representation is that of being the eternal child, "content to let her elders – parents, lawyers, public servants – decide how much she could know about her origins, as they saw them" (Else, 1991, p. 145). While this makes intuitive sense, no research was found to support this contention.

It is also proposed that challenges unique to the adoptive parents have an impact on the adopted child's developing self-representation. Brinich (1980) makes a controversial claim that the adoptive parents have a particular problem in resolving their ambivalence toward the adopted child. He contends that despite being loved, the child also represents the parents' failure to conceive, and that the child's unknown heritage

provides an excellent opportunity for “the externalisation of instinctual behaviour; the child then becomes two different children to the adoptive parents: “our” good child and “their” bad child” (p. 9). It is suggested that the child becomes aware of these two parental representations and most likely incorporates them into his or her self-representation. This provides an alternative explanation of the phenomenon of splitting in the adoptee, described in the section above. The majority of literature regarding this phenomenon supports the child based form of splitting on the basis of the challenge in integrating two sets of parents. While I agree with the child based form of splitting, if the adoptive parents are also splitting their representation of their adopted child, this will likely intensify the child’s splitting.

There is some support for this claim of parental ambivalence in research by Frankel (1991) which presents pooled data from 20 cases exploring factors contributing to the difficulties of early and late adopted children. Frankel reported parental ambivalence in the early adopted group and proposed that in this group, “the bonds between adoptive parents and early adoptees appeared to be subtly inadequate and in most cases were characterised by progressive detachment by the adoptive parents” (p. 8). This research was specific to the clinical population of adoptees and cannot be generalised to the non-clinical population.

Fisher (2001) argues against this notion of the inevitability of a negatively coloured self-representation, suggesting that “the vulnerability to loss in all adopted children can be managed well in an adoptive environment that is loving, connecting, and able to manage anxieties of all kinds, including parental grief at infertility” (p. 153).

Unfortunately, Fisher provides no evidence for this assertion. Fisher’s argument seems to reflect increased awareness of the impacts of adoption on adoptive parents over the last several decades. She assumes an active stance on behalf of adoptive parents in dealing with such issues. No data were provided on the incidence of such proactive behaviours.

I agree with Hodges’ (1990) conclusion that we need to acknowledge that biological parents may never be relinquished, especially as their representation which includes the act of relinquishment, is likely to have partially formed the self-representation. “And once inscribed there, can the self-representation lose such parts of itself without leaving behind at least a vulnerability, a shadow of the past?” (p. 71).

Psychosocial Risks for the Adopted Person Related to Adoption

There is a great deal of research on the many psychosocial impacts of adoption on adoptees throughout the lifespan. Adoptees have significant experiences of loss, beginning with the loss of the birthmother (Deeg, 1989; Doka, 1989; Levy and Orlans, as cited in Johnson & Whiffen, 2003; Saiz and Main, 2004) and often show attachment related difficulties (Yarrow & Goodwin, 1973; Yarrow et al., 1973). These distortions in early parent-child attachments within the adoptive triad may then impact developing aspects of both intrapsychic object relations and interpersonal relationships for the adopted person described above (Brinich, 1995). This is manifest in the adoptee's well documented fear of abandonment (Brodzinsky et al., 1998; Fischman 1996; Lifton, 1990; Silverman, 1985-1986).

In working with adopted children, several psychoanalysts have also noted the adoptee's difficulty in integrating love and hate (Brinich, 1995; Eiduson & Livermore, 1953; Glenn, 1985-1986; Wieder, 1977). During adolescence, many adoptees struggle with developing a secure identity (Lifton, 1979; Sants, 1964; Sorosky et al., 1975, 1979; Brodzinsky, 1987) and these identity concerns appear to persist into adulthood (Sorosky et al., 1975).

Hodges (1984) claims that a self-representation of being unwanted creates difficulties for the child's development of self-esteem and sense of worth. This argument is supported by many authors (Brinich, 1995; Greenberg, 1997; Nickman, 1985; Samuel, 2003; Wieder, 1977). It is clear that the process of adoption, particularly closed stranger adoption, can have a multitude of far reaching effects for the adoptee. (See Appendix C for a fuller discussion of the psychosocial impacts of adoption.)

Summary

While most adoptees are within the normative range on most psychological measures, comparisons of adopted and non-adopted populations do indicate that adoption creates a psychological risk for the adopted person. The most commonly cited impacts of adoption in the literature are multiple losses and challenges with grieving, impaired attachment and fear of abandonment, difficulties with identity formation and challenges to integration of love and hate leading to split object relations. These impacts

then have consequences for the adopted person's developing self-representation and the development of self esteem.

These psychosocial impacts and consequent self and object representations affect the adopted person's interpersonal relating, and by extension the therapeutic relationship. This will be elaborated in chapter five.

Chapter Five

The Impact on the Therapeutic Relationship of the Client Being Adopted

A summary and critique of literature regarding the impact of client adoptive status on the therapeutic relationship will be presented using an object relations lens. Work with an adopted client will be introduced to illustrate the effect on the relationship.

A broad range of critical variables exists in any psychotherapeutic encounter. Some of these variables which require specific consideration for the adoptee are: the goal of therapy with the adoptee, recommendations for assessment, unique aspects of transference and countertransference, exploration of the adoptee's fantasies surrounding relinquishment as defence mechanisms, search and reunion implications, and the impact of adoptive status on therapy termination. The chapter will conclude with a critique of the object relations lens as the preferred theoretical framework for exploring clinical material with adopted clients, and a description of my learning from my work with Tracy.

Introducing Tracy

Tracy (not her real name), a solo mother in her early thirties, presented for therapy having felt depressed most of her life. She had low self-esteem, intense self-criticism, interpersonal difficulties, feeling on edge and sometimes taking things out on her daughter.

She shared in the initial assessment that she was adopted, and had been left alone in the hospital for 10 days until she was taken home⁴. She noted that her birth mother had post partum depression. Tracy showed little emotion as she talked about these aspects of her history.

Tracy raised the subject of her adoption again in our eighth session, in the context of feeling hurt by her (adopted) brother, claiming "he's not really my brother

⁴ This would have been a significant additional trauma for Tracy, and while such separation trauma is more common among adoptees, the effects of such trauma are not the focus of this dissertation.

anyway” putting distance between them in an attempt to ward off her hurt feelings. She felt ‘different’ from the rest of her adoptive family, and recalled wondering why her birth parents had given her up, thinking “there must have been something wrong with me”. In her self-representation Tracy was defective, and not worthy of being loved. She went on to talk about her difficulties identifying with her birth mother and half sisters, with whom she made contact at age sixteen, saying “she wears thick bifocal glasses and buys her clothes at the market” whereas Tracy’s adoptive mother wore nice clothes and drove a nice car. Tracy was struggling to establish her identity and her place in the world saying, “I don’t fit into their family, but I don’t fit into my family either, maybe I’m never going to fit in”. I connected with her isolation, having my own feelings of difference, and lack of belonging, and identified with her last bastion of hope, “maybe I’ll fit in with my Dad’s family”.

Unfortunately, in a process parallel to my own more recent one, Tracy was blocked from learning her birth father’s identity by her maternal grandmother, and her hurt at this further rejection sent her hopes underground.

I often felt paralysed by my own fear of Tracy’s rejection. Tracy had rejected her own birth family, dis-identifying with their neediness, claiming “I’m not a needy person”. Wanting to hold on to my position as the idealised maternal object, I kept my distance from Tracy, not making any demands of her. Important questions about what she was told about why she was given up and what her fantasy of her birth mother was, went unasked, and unexplored, just as they had not been explored with her birth mother.

Assessment and Therapeutic Goals with the Adopted Person

A thorough history taking during the assessment phase is important in order to prompt a disclosure of adoption. Having discovered a client is adopted, some therapists claim there is significant value for the developing therapeutic relationship in asking questions pertinent to adoption such as: When were they adopted? That is, what year? Why were they adopted? What were the circumstances surrounding their adoption? Why were they adopted into their particular family? Was it due to the infertility of the couple, or did the family particularly want a daughter? What happened for them after their birth? (L. Brokenshire, personal communication, 22 August, 2007; Winkler,

Brown, Keppel & Blanchard, 1988). The answers to these questions will then help the therapist and client to establish appropriate therapeutic goals.

There is some debate among clinicians about unique therapeutic goals in working with the adoptee. Some suggest that the adopted person's unique goal in therapy and perhaps in life is to be able to accept their adopted status, which includes an ability to relinquish their biological parents. For example Kernberg (1985-1986) proposes:

The adoptive child's unique developmental task is to become the true adoptive child of true adoptive parents. This means that he or she must accept the parent-child ties, a simultaneous acceptance of being an adopted child and also the natural child of unknown biological parents. (p. 295)

Presumably, such a proposition was made in the context of closed adoption, given the assumption of "unknown biological parents". In the social context of open adoption that exists to varying degrees in Aotearoa currently, a goal of relinquishing biological parents seems inappropriate, especially given Hodges' (1990) conclusions cited on page 32.

Clearly, the working through (see Appendix D) of adoption issues can only occur when the client is ready. While no research was found on this subject, certainly, I was unwilling for the first three years of therapy with my first therapist to even acknowledge my adoption as a subject worthy of our attention.

Hodges (1990) more realistically suggests that "perhaps we have to acknowledge that at some levels the biological parents may never be relinquished; their loss, first understood as abandonment, never entirely dealt with" (p. 71). She proposes that these parental objects and their associated loss become part of the self-representation for the adopted person, and that while these aspects may be mourned, they cannot be erased.

I agree with Kernberg's additional proposition that "a primary goal is to conduct a full exploration of identifications with adoptive and natural parental images" (Kernberg, 1985-1986, p. 294). In exploring these identifications, she suggests that a beneficial outcome for the client is a greater tolerance for ambiguity, and a corresponding decreased need for splitting these two sets of parental images.

In summary, clients enter therapy at various stages of readiness and willingness to work through adoption issues. As the review of clinical material has shown, the adoption itself is unlikely to be the presenting issue and indeed may never be considered to be a source of difficulty. Although it is not discussed in the literature, my personal experience and that with my client suggests that it is imperative that the therapist honours the client's defences; otherwise the client may unconsciously fear disintegration and leave or feel that the therapist is more interested in his or her agenda. It is therefore important, that the therapist hold adoption and its associated challenges in mind, and be willing to test out opportunities for making connections between presenting problems and some of the well documented dynamics of adoption.

Building a Working Alliance

Adoption dynamics have a strong impact on the alliance stage of therapy and the therapist is likely to be quickly abandoned if he or she is not prepared for them. It has been noted that adopted clients are often extremely resistant to exploring adoption (Freeman & Freund, 1998; Zuckerman 2000, as cited in Zuckerman & Buchsbaum, 2000).

Kernberg (1985-1986) has proposed that the timing of adoption related interpretations is crucial. Interpretations early in treatment, before transferences (see Appendix D) are active (when there is no context for the client to understand how adoption issues play out in relationships) are likely to increase the adopted client's defences, and may even drive the subject of adoption underground. It is possible however, as a number of clinicians have attested (Lousada, 1993; Ravagli, 1999; Samuel 2003), that some transferences relevant to the adoptee may be in effect from very early in the treatment, perhaps even from the initial contact. One example of this is the transference to the therapist as the idealised biological parent.

In the early stages of therapy with the adopted person, it is therefore important to be sensitive to the existence of transferences, but wary of interpreting them before one has determined the client's level of comfort with and defences surrounding adoption.

Lack of Knowledge of Biological Parents

Normally, with knowledge of a client's parents, it is fairly easy for the therapist to discern the origin of a parental transference. Where the adoptee has not met the biological parents there will be greater difficulty in making specific transference interpretations due to a lack of knowledge about them (Deeg, 2002).

Deeg (2002) argues that the self-representation of the adoptee is 'under construction' and suggests the therapist guide the client in discovering his or her self through the exploration of fantasy and interaction with others:

Although you cannot see yourself through memories of your interaction with your birth mother, let us now focus on the revelation of your self vis-a-vis others and here with me. Let us also encounter you in deciphering your fantasies of the birth mother you wish for, and the birth mother you dread. (p. 198)

With increasing numbers of children participating in open adoption, the transferences occurring in the therapeutic relationship will be more easily attributable to either biological or adoptive parents.

Transferences for the Adopted Person

Binary or split transference.

Several clinicians have identified a particular kind of transference in working with adopted client's respectively referred to as a binary, or split transference (Brinich, 1980; Deeg, 2002; Hertz, 1998). Deeg (2002) states that "the binary transference refers to the adoptee's projection of internalised relations with both sets of parents onto the person of the therapist" (p. 196).

Supporting this notion of split transference, Hertz (1998) claims the commonly reported fear of abandonment by the therapist represents the internalised birth mother, and feelings of gratefulness toward the 'saviour' therapist represent the internalised adoptive parents. In a reversal of this split, Hertz proposes that further on in treatment, a positive transference may develop in which the therapist is viewed as the idealised fantasied birth mother, and a negative transference counter to this is the "disconnected adoptive mother" (p. 107).

Wieder (1977) in his analysis of seventeen-year-old Pete understood that the idealisation of the therapist represented the unconscious attitudes toward the adoptive mother and debasement represented the attitudes towards the biological mother (p. 3).

Interestingly, I found the opposite split for myself in therapy. I began a search for a second therapist while still in my first therapy on the conscious pretext of wanting to experience therapy in a different modality. I was seeing a female therapist and sought out another similar-aged female therapist. When I revealed this it wasn't interpreted in the adoption context, but rather the therapist said something to which I responded by feeling I had done the wrong thing. I didn't understand my motives at the time. In hindsight, I believe I was unconsciously setting up the search for a fantasy idealised biological mother in a way that I wouldn't be rejected, one in which I had all the control. This is an example of why it is important for the therapist to be aware of adoption issues.

Siegel & Siegel (2001) conclude that the adopted child's need for an idealisable object has been thwarted by a disruption in the idealisability of the adoptive parents. While they do not explain this conclusion, Zuckerman & Buchsbaum (2000) offer some insight. They assert that the adoptee, being of different origins, "is unconsciously directed toward distinguishing herself particularly from her adoptive parents in an intense pursuit of her own identity" (p. 23). This results in a persistent fantasy of an idealised birth parent.

These authors have too quickly generalised from their experience to a rule. The implication of this concept of the binary transference for the therapeutic relationship is that the therapist be alert to splitting of 'good' and 'bad' aspects of parental figures given that adoptive and biological parents may be either devalued or idealised. The different dynamics described in the literature above indicate that various patterns are possible and it is important that the therapist be open and not prejudge.

The Hole-Object Transference.

Quinodoz (1996) describes her work with an adoptee she calls Laure, and refers to a 'hole-object' in relation to the internalised biological parents:

When I represented the hole-object in this patient's transference, I would meet with neither transference love, nor transference hate, but only indifference – which took on the quality of an affect only by contrast with the feelings she expressed to me in the other form of transference when I represented for her an object that existed. (p. 2)

In support of this unique transference, Freeman & Freund (1990) suggest the therapist is likely to encounter feelings of unreality or non-existence in working with adopted clients, due to the client's ethereal sense of self.

Quinodoz (1996) worked through this 'hole-object' transference by naming and giving a voice to this non-existent object. This facilitated the client's awareness of her projections and helped her to recognise and integrate the split between her pre and post adoptive self-representations. Quinodoz asserts that the key role for the therapist in facilitating the integration of this split is accepting both the adoptive and abandoning parental roles in the transference. The client is thus able to comprehend the juxtaposition of these two incompatible roles, and come to view and internalise a new, more singular parent representing a synthesis of these earlier competing images. It is proposed that the client will subsequently be able to view and integrate the abandoned aspects of his or her self-representation. This isn't to say that the adoptee has to give up the biological parents, but rather to establish a double identification, where he or she accepts both the adoption and the abandonment. This fits with Hodges (1990) view, as biological parents are not relinquished or rejected.

Quinodoz describes her adopted client having integrated both sets of parents, "from then on it was no longer tragic if she sensed the slightest whiff of rejection" by her adoptive parents and she was able to fantasise positive qualities in her biological parents, as revealed in the following comment: "actually my mother trusted me, she let me be born because she thought I would be able to manage in life, even without her help" (p. 332).

Negative transference.

Zuckerman and Buchsbaum (2000) make explicit several possible negative transference dynamics in relationship with the adopted person. They suggest that the

adoptee in feeling chronically defective and unworthy⁵, may project these feelings onto the therapist, seeing him or her as equally or more so, or that the therapist disapproves of the client's flawed self, or finally that the therapist in valuing the client, does not fully see her.

Reeves (1971) proposes that the adoption context sets the scene for an instability in the therapeutic relationship. He suggests that an initial positive transference may develop manifesting in engagement with the therapist, but that inevitably this is followed by disintegration into a negative transferential disillusionment. He contends that this pattern represents "an enactment of the adoptee's original experience of attachment followed by rejection, creating fragile connections that mirror this original experience" (Zuckerman & Buchsbaum, 2000, p. 14). Thus the notion of an 'unstable' transference.

Zuckerman and Buchsbaum (2000) advocate for the therapist's initiation of dialogue about adoption themes in the midst of such fluctuating transferences. They propose identifying the parallel with the adoptee's transition from early attachment to loss and the corresponding difficulty in integrating two discrepant parental representations. I agree and believe such a dialogue would have been helpful for me as a client when I acted out my binary transference with my therapist. This idea also fits with Quinodoz' (1996) suggestion of the therapist interpreting and accepting both the abandoning and adopting transferential roles. In my work with Tracy, at the point I was feeling fearful of her rejection it would have been useful to introduce this concept of split parental objects, with me being afraid of being put in the role of the abandoning mother.

Countertransferences with the Adopted Person

Countertransferences (see Appendix D) with the adopted person are many and varied, however the main themes in the literature include the pull toward either side of the transferential split (good or bad parents) (Quinodoz, 1996; Samuel 2003), feelings of non-existence (Freeman & Freund, 1998; Quinodoz, 1996), confusion, rejection and

⁵ This seems to suggest that all adoptees feel this, however as discussed in chapter four, the majority of adoptees are within the normative range on psychological measures. These authors need to explicitly state that they are describing the adoptee in treatment who has a self-representation as unwanted and unwanted, see page 31.

anger (Zuckerman & Buchsbaum, 2000), difficulties in thinking (Bartram, 2003; Ravagli, 1999) and anxiety related to letting the client down (Kernberg, 1985-1986). I would like to add from my own experience as a therapist in working with an adoptee, fear of pursuing adoption themes in the face of denial, as well as aloofness and distance. For example, as Tracy spoke about wanting to find her father for medical reasons, it seemed to be too difficult for her to acknowledge that she wanted to find a father she could feel closer to, however I felt reluctant to pursue these underlying reasons. Quinodoz (1996) describes her countertransference with 'Laure':

I had deep down wanted to be 'good', and that I had therefore unwittingly declined to accept the transference role of abandoning parents; I had instead unconsciously demanded the part of adoptive parents! I had aided and abetted a split. (p. 3)

Wilkinson & Hough (1996) advocate for the value of countertransference in understanding the adoptee who has a tendency to lie, or to 'bend' the truth. Given the lack of access to the 'real' stories of some adoptee's early childhood, they suggest that the therapist use her countertransference to recognise the drama being enacted, and the respective roles being cast, such as passive onlooker. They claim that, "for these youths, uncovering the earliest objects within their inner world required some measure of creating those objects (p. 8).

Countertransference feelings of paralysis and confusion are noted by Zuckerman & Buchsbaum (2000) in their work with adoptees who offer and then retract affect laden information. They propose that these feelings signal defences against the young adoptee's fear that the therapeutic relationship "might further jeopardise her already tentative position within the adoptive family" (p. 25).

Difficulty in thinking is another countertransference that has been identified in working with adopted clients. Ravagli (1999) describes therapy with six year old Vasja and summarises her countertransference experience, "there was the possibility of discharging into the therapist, intense almost unbearable feelings, the recurring theme being that of abandonment, and difficulties in thinking and learning" (p. 447).

The Role of Fantasy in the Relationship

Parental fantasies play a significant part of the mental life of the adopted person, particularly for those in closed adoption. Common, although not unique to, the treatment of adoptees, is a desire to be adopted by the therapist (Brinich, 1980; L, Brokenshire, personal communication, 22 August, 2007; Wagonfeld and Emde, 1982). In fact, for many adoptees this desire may indicate a fantasy that the therapist is a biological parent, come to 'reclaim' the child, in an unconscious attempt to undo the original abandonment (Bertocci & Schecter, 1991; Brinich, 1980; Colarusso, 1987).

Hodges (1990) in her clinical work with adopted children describes the most common fantasies of adoptees in relation to their adoption. She talks of fantasies that mask the pain of abandonment. For example, the adoptee replaces "She gave me up, she did not want me" with "It's not that she didn't want me; she physically wasn't able to keep me". This was my personal fantasy, fed by the information given to me by my adoptive parents about my birth mother. I never entertained for a minute the idea that she might have been able to keep me. Another fantasy described by adoptees claims "She did want me, I was taken away by force". This fantasy is of being kidnapped by the adoptive parents, one which transforms "the "unwanted" child into a child wanted twice over" (Hodges, 1990, p. 64).

Some adopted clients may resist the opportunity to explore their fantasies of biological parents, decriing its pointlessness. Deeg (2002) writes of an adult adopted woman who felt that due to her lack of actual contact with biological parents, there was no point in exploring fantasies about them. Deeg suggested that "her rejection of fantasy portrayed an enactment of her need to reject her unreliable biological mother and simultaneously gratified a desire for revenge that expressed her pained representation of abandoned infant self" (p. 200).

It is proposed that the value in exploring these fantasied representations of biological parents is in making them more explicit, aiding differentiation, identification and subsequent integration. Deeg (2002) claims that:

As affects and fantasies toward the biological parent become more freely expressed within the treatment, both the adoptee's representation of the biological parent and the adopted self become richer, less threatening, and more integrated into the adoptee's identity. (p. 202)

Fear of Abandonment by the Therapist

Many authors have written about the adopted person's fear of being abandoned by the therapist (Brinich, 1980; Freeman & Freund, 1998; Ravagli, 1999; Rustin, 1999; Wagonfeld and Emde, 1982; Zuckerman & Buchsbaum, 2000).

Frankel (1991) identifies this overwhelming anxiety of not being worthy of being kept as a key focus for psychotherapy with adopted clients. He proposes that adoptive parents, and I would suggest also therapists, are not able to be used fully for the purposes of identification until this anxiety can be worked through.

This fear of abandonment is often displayed in the adopted client's repeated testing of the therapist's commitment (Brinich, 1980; Zuckerman & Buchsbaum, 2000). Brinich (1980) describes a case of a male client whose repeated testing of the analyst's commitment seemed a re-enactment of his testing of his adoptive parents. Brinich noted that although the client had never been abandoned (presumably he meant by himself) he reflected that his client reacted as if the threat of abandonment was ever-present.

Deeg (2002) advocates the therapist communicating to the adopted client grappling with autonomy issues in the face of abandonment fears, the value in the therapist and client working together to understand the client's dynamics. Empathic exploration of the client's struggle regarding attachment and separation can also help to deepen the therapeutic relationship. Bertocci and Schechter (1991) contend that the feeling underlying this conflict is a powerful desire for a biological connection.

Dependency, Shame and Rage

Once the adopted client's defences against rejection have been worked through enough to allow an attachment to form, the client's vulnerability as a result of growing dependency may become heightened. Bertocci and Scechter (1991) describe announcements of the session's end, or the therapist's holidays as being crushing to the client and resurrecting feelings of being unwanted or unlikeable. The therapist needs to be aware that his or her time off is likely to trigger abandonment issues.

Connected powerfully to feelings of dependency and need in the adopted person, is often shame and rage. Whitman-Raymond (2005) recounts the case of "Della", an

adult adopted woman who sought treatment for infidelity to her husband. He asserts that need-based shame often underlies narcissistic rage:

The self may thus attempt to purge shame through attacks on objects.....one of the most frequent sources of the shame-rage relationship is the subjective experience of need, about which the self experiences a sense of intense humiliation....the self-experience is one of being pathetic, ridiculous or insignificant. (p. 346)

Deeg (1989) claims that adult adoptees in therapy are unlikely to be conscious of powerful feelings of rage toward biological parents. Rather, clients seem to have feelings of indifference regarding adoption (which was certainly the case for me for the first five years of my therapeutic journey) or a mildly positive interest in the subject. He suggests that these dispassionate presenting attitudes mask a much deeper emotional investment in these parental figures of longing and aggression:

Exploration of these and similar presenting attitudes revealed that on one level, they screened an underlying cathexis of an idealised, longed-for, birth-mother, which itself was part of a deeper defensive constellation formed around aggressive cathexes. (p. 159)

The Interaction of Therapy with Search and Reunion

Each adopted person (adopted through closed adoption) who enters therapy does so with unique feelings about the idea of searching for and being reunited with their biological parents. Some may be considering the search, some may be in reunion, and some may be altogether disinterested.

The uniqueness in the original adoptive loss is that “since the loss is by socio-legal protocols rather than by death, the loss is potentially reversible” (Deeg, 2002, p. 184). I would argue against any loss being reversible, particularly not the loss of biological parents. However, Deeg’s point seems to be that in the adoptee’s case, the loss need not be permanent. He suggests that in attempting to repair the disruption of the original separation, the adopted person may begin a search for the lost object.

Often adopted people will wait until their adoptive parents have passed away before beginning a search for biological parents, out of fear of hurting them (Sorosky, Baran & Pannor, 1976; Greenberg, 1997). For others, it may be the support of a therapist that helps them find the courage to begin a search. Sorosky, Baran & Panor (1975) describe a client who, prior to having therapy, was fearful of beginning a search

and found that, “knowing that she had the support of her therapist gave her the courage to approach the agency that had placed her for adoption” (p. 186).

Lifton (1990) strongly advocates encouraging the adoptee to discover information about her genealogy suggesting that “some adoptees will not be able to bond with their adoptive parents until they are released by their birth parents” (p. 90). This is a very strong statement with serious implications for those adoptees that may never be able to access information about their biological origins or indeed locate and meet birth parents.

Genetic Sexual Attraction

In working with a client who is considering a reunion, it may be useful to discuss the intensity of emotion that can be felt upon first meeting; an intensity which for a small number of biological parent child pairs has extended into sexual attraction. The term genetic sexual attraction was coined by Barbara Gonyo (1987), to describe intense erotic feelings felt following reunion by relatives who were separated at birth. Hinsz, (as cited in Greenberg, 1997) proposed that:

The need to demonstrate a closeness and intimacy, which had been feared lost, could well translate itself, between sexually active adults, into sexual intercourse; and this likelihood might be reinforced by any physical similarity which increases the attraction. (p. 95)

This is an unusual issue though it symbolises the intensity of the adoptee-birthparent relationship. Consequently for reasons of space it will not be discussed further in this dissertation.

To summarise, several issues require consideration when assisting a client in making a decision about beginning a search for biological parents. These include exploring the client’s motives for instigating the search, conversations around their fantasies and fears regarding reunion, consideration of how relationships with significant others (in both the adoptive and biological family) may be impacted, and what communication may need to happen with adoptive relatives prior to beginning a search. Also, for key consideration is the client’s readiness for all possible outcomes, including the possibility of further rejection.

The main consideration is that the therapist supports the adopted client in giving themselves plenty of time throughout each step of the process, and continuously monitors how well the client is coping (Brodzinsky, Smith & Brodzinsky, 1998).

Impact of Adoption on Termination of Therapy

Given the adopted client's history of abandonment, the process of ending an intimate relationship such as the therapeutic one, requires particular sensitivity. "In general termination for the adoptee bespeaks the resurgence of the specific manifestation of abandonment and adoption fantasies" (Deeg, 2002, p. 203).

The adopted client's earliest experience of separation was a traumatic one, prior to having the cognitive capacity to comprehend the experience, and the verbal skills to articulate the feelings that went with it. It is therefore important to use the termination of therapy for a new and different experience for the client, in which they have the opportunity to create a more active experience, with some measure of control, including the time and space to connect with past and current feelings, and give them voice. Kernberg (1985-86) noted in approaching termination with 'Bert' he found it reassuring to control when and how he was going to terminate.

Some clients may be so fearful of the process that they try to avoid ending altogether. Samuel (2003) described her premature ending with Mrs B, who:

could not stand the idea that the therapy would have to end one day and so would rather end it now, when she felt she had got something from me and could manage without me, than at a later date, when she did not know what state she would be in. (p. 213)

Critique of the Object Relations Lens for Exploring the Therapeutic Relationship with the Adopted Person

Brodzinsky (1990) is critical of the evidence on which our knowledge about adoption is based. He claims "to date, the majority of our knowledge about the development of adopted children rests on casework and clinical observation, and a small body of atheoretical research" (p. 24). He suggests that casework and clinical data suffer from limitations of observer objectivity and problems in generalisability and that

atheoretical research is questionable due to the lack of a conceptual framework within which to make sense of the findings.

I have demonstrated that an Object Relations model is particularly useful for understanding the intra-psychic and interpersonal dynamics of the adopted person in treatment; however, this model is limited in that it does not address the broad range of psychosocial factors impacting adoptees. Nor does it account for the fact that the vast majority of adoptees are not in treatment and appear to function as well in the world as non-adoptees (Frankel, 1991). A broader perspective on the psychosocial impacts of adoption is provided by Brodzinsky's (1990) Stress and Coping Model of Adoption Adjustment mentioned in the appendix on the Psychosocial Impacts of adoption on page 81.

The foundation of the model is that children's adjustment to adoption is mediated by various cognitive appraisal processes and coping efforts. These processes include the child's awareness and evaluation of adoption related losses as well as their use of problem and emotion focussed coping strategies. The model also factors in biological variables such as the adopted person's genetics and prenatal experiences, along with environmental variables such as cultural and societal demands, constraints and resources, social supports, familial demands and placement history. Finally, of significant importance in the model are a range of person variables, including the adopted person's cognitive level, self-esteem, sense of mastery and control, values and interpersonal trust.

While an object relations model offers some extremely useful insights into the internal world of the adopted person and his or her expected relations with significant others, the therapist needs to also pay attention to the broad range of variables described above, in understanding the adopted person's functioning and in building on their strengths within the therapeutic setting. For research purposes, this model "offers the investigator a clear theoretical context, with substantial generative power, to guide his or her empirical endeavours" (Brodzinsky, 1990, p. 24).

Brodzinsky et al. (1998) claim that the therapist's modality is of minor importance in working with the adopted person. Of more importance is:

A clear understanding of the adoption-related issues that are likely to emerge in the course of treatment and the availability of specific intervention strategies,

incorporated into an overall treatment plan, that can help adoptees work through their unique life circumstances. (p. 89)

What Brodzinsky is failing to understand is that the object relations model is what provides a clear understanding of the intra-psycho dynamics of the adoptee including splitting and the associated transferences described above.

Tracy Revisited

Tracy didn't raise the subject of adoption again. Four months into therapy, as Tracy was becoming attached to me, she began talking about taking a trip overseas the following year. She was excited by this idea, commenting that her friend had said she would "come back a different person, with more self-confidence". Tracy was fantasising a shorter, less painful route to achieving her therapeutic goals.

As we approached my four week Christmas break, not fully aware of my own pain around separations, I minimised the break for both of us, along with my importance to Tracy, not initiating any conversation around it until the week before, and even then, focussing on the support she would have over the break. Unsurprisingly, in hindsight, she cancelled the last session, perhaps seeing me transferentially as another abandoning maternal object.

The following year, I saw Tracy for a further eight months. She decided to end therapy before going on her trip. Perhaps she wanted to leave me with the fantasied 'new and improved' Tracy. While I felt that Tracy was on the road to discovering herself and becoming an adult with her own sense of who she is and what she wanted for her life, I felt sad for our losses: the loss of relationship and the loss of opportunity to further explore Tracy's feelings around her adoption and her fantasied reunion with her birth father. Tracy felt she had made significant progress toward her goals in therapy. I wonder if she left me before I could leave her, knowing that my placement at the therapy agency would soon finish. Tracy fully participated in our ending of therapy, after experiencing some initial fear of doing so. This was a new, more active and mutual experience of ending for her.

Summary

It has been argued that few therapists are able to reach adoptees because they are unfamiliar with the psychodynamics of the adopted person. Lifton (1990) claims that until recently, “therapists have colluded with society in disavowing the reality that adoptive families are not the same as other families, and adopted children the same as other children” (p. 89). She suggests the majority of therapists do not consider adoption impacts to be a fundamental part of treatment with the adopted person because this was not part of their training. Twelve years later, adoption was still not covered as an aspect of my training.

It is clear that adoption, having consequences for the development of the adopted person’s self and object representations, also has consequences for the therapeutic encounter. It is therefore important that therapists beginning work with adopted clients are aware of these potential consequences.

Adoption is unlikely to be the presenting issue for an adoptee entering treatment. However, when the client is ready, it is likely that an exploration of the client’s identifications with both adoptive and biological parents will be essential in understanding the client’s object relations. Several clinicians who are familiar with the cluster of adoption experiences recommend that specific adoption questions be asked during the assessment once it is ascertained that a client is adopted. A key consideration in both setting of goals and assessment is that the therapist honour the client’s defences and be mindful of opportunities for making connections concerning adoption dynamics.

In working with the client adopted through closed adoption protocols, there are a range of unique aspects of transference and countertransference. A binary transference reflecting the split representations of biological and adoptive parents is well documented. Also identified is the potential for a hole-object transference, which leaves the therapist feeling non-existent. Interpretation of such transferences is often complicated due to the lack of knowledge of biological parents. In these cases the therapist is reliant on an exploration of the client’s fantasies. The most commonly reported countertransferences include being pulled into a transference related to either side of the splitting, difficulties in thinking, and fears of letting the client down.

The nature of the original loss in adoption is unique in that there is the opportunity for reunion with biological parents. Of significance for the therapist

working with the adopted person is knowledge of the client's stage of search and reunion both internally and externally.

The adoptee client is likely to experience increased anxiety at the onset of the termination phase of therapy. For some clients this may manifest in attempts to avoid endings altogether. The therapist needs to allow more space for working through the termination process also allowing the client some control in determining the pace of termination.

It is clear, that an object relations lens is particularly useful for understanding the dynamics of adoption as they impact on the therapeutic relationship and the therapist also needs to attend to The Stress and Coping Model of Adoption Adjustment which offers a broader perspective including a range of factors that would be beneficial for the therapist to consider in working with the adopted client.

In summary, mental health practitioners must come to appreciate the need for knowledge of adoption dynamics in working with such clients, given the numbers of adoptees entering therapy. It is also important that the therapist, while honouring the client's defences, does not collude with the client's resistance to explore this subject. Sometimes it may require the therapist to raise the subject, and continue doing so intermittently. Therapists who have enquired about adoption or addressed adoption have been perceived by adoptees as being significantly more prepared and helpful compared to those therapists who do not (Sass & Henderson, 2002).

Equally, it is important that the impacts of adoption are not overestimated or too rigorously pursued. Instead, "a task for the therapist and the patient is to give the adoption its proper psychic space" (Treacher & Katz, 2000, p. 209).

This chapter has summarised the impact on the therapeutic relationship of the client being adopted. Given that there are therapeutic relationships in which the therapist is also adopted, the following chapter will explore the impact of the therapist's adoptive status on this relationship.

Chapter Six

The Impact on the Therapy Relationship of the Therapist being Adopted

This chapter will present ideas about the impact of the therapist as adoptee on the therapeutic relationship. In conducting my literature search, I found scant material on this subject. Given anecdotal evidence suggesting that adoptees are also overrepresented as mental health professionals, it seems valuable to speculate on such impacts. The following variables seem to warrant particular consideration by the adoptee therapist in working with an adopted client: identification and overidentification with the client, personal process issues, the adopted therapist's experience of and position on search and reunion, and the impact of the therapist disclosing his or her adoptive status. These variables will be discussed drawing extensively on my personal experience as well as concepts from the literature; however the overall theme is that it is essential that the adoptee therapist has done extensive work on these issues.

Identification and Overidentification

Identification has been defined as "the analyst's capacity to place himself in another person's shoes" (Sandler, Dare & Holder, p. 93). In the therapeutic context, the therapist's ability to identify with the client impacts on the development of the therapeutic alliance and on the therapist's empathy for the client.

Lifton (1990) noted that the therapist who is adopted knows the cluster of adoption issues from the inside. This includes abandonment, loss, being adopted, growing up with strangers, and possibly search and reunion. The implication of this intimate knowledge is that the adopted therapist is much less likely to minimise adoption issues, and indeed may be more likely to over emphasise the issues (Treacher & Katz, 2000).

Being an adopted person myself, one might assume I was more likely to focus on the impact of my client's adoption on our relationship, and her relationships with others. However, this was not my experience. Instead, I experienced a tendency to

collude in a minimisation of adoption related issues. I was also inclined to over-identify. Why did this happen? Clarkson (2003) terms this kind of identification concordant proactive countertransference, and suggests it is an artefact of the therapist's unresolved issues.

Freud (1910d, as cited in Sandler, Dare & Holder, 1992) suggested that we can only take our clients as far as we have come in our own personal process, "no psychoanalyst goes further than his own complexes and internal resistances permit" (p. 82). If the adopted therapist has not fully explored his or her own pain around abandonment issues, this is likely to impede the progress of the adopted client. The therapist may have 'blindspots' regarding issues they have not worked through themselves (Freud, 1912e, as cited in Sandler, Dare & Holder, 1992).

The adopted therapist will need to have explored for themselves fear of rejection and abandonment, identity issues, oedipal conflict resolution linked with the resolution of the family romance fantasy, feelings and philosophy around search and reunion, and finally whether to disclose to the client his or her adoptive status. As I have done work on these issues I feel more able to contain them with clients.

Fear of Abandonment

If the therapist who is adopted has not processed his or her own anxieties around abandonment (as discussed in Chapter Five) enough to be able to tolerate being left, he or she may unconsciously hold on to clients. Another possible consequence is the avoidance of evoking negative transference out of fear of being unlikeable or unwanted and then perhaps abandoned. The therapist may be more comfortable instigating endings rather than allowing a natural ending to occur.

Oedipal Resolution and the Family Romance Fantasy

If the adopted child has not given up the idealised birth parents psychically, he will not be able to fully identify with the same sex parent and thus will not be able to establish a realistic and tolerant sense of himself and others that results from such an identification. "He will therefore unrealistically idealise some people and diminish others" (Fisher, 2001, p. 150).

Consequently, if the adoptee therapist has not done significant work toward oedipal resolution she may be unaware of her own splitting of parental objects. This lack of awareness may then extend to her client and disrupt her ability to understand and support the working through of her client's search for the idealisable object.

Identity, Search and Reunion

Given the challenges to identity formation for adoptees and the significance of search and reunion for this process, consideration must be given to the adoptee therapist's identity development in working with an adopted client. How much does the therapist know about his or her origins? Does this have an impact on the therapeutic relationship? What if the therapist experienced closed stranger adoption and does not know much about his or her origins? The issue would seem to be more whether the therapist has been able to establish a solid identity, not whether or not he or she has chosen to search.

If the client is further in the reunion process than the therapist, this may impact the therapist's ability to be present to where the client is in her process. What if the therapist has found his or her parents and had a difficult experience of rejection? Could the therapist project their own wishes for a positive reunion on to the client if they have not felt successful in reunion? These are all issues that the adopted therapist must be aware of in working with the adopted client.

The adopted therapist, irrespective of search and reunion, is more likely to understand the loss and groundlessness involved in not knowing one's origins. A consequence of this may be that the adopted therapist has a stronger position than a non-adopted therapist on search and reunion for the client's identity formation.

Another unique impact on the relationship when both client and therapist are adopted may be the therapist's fantasy of a biological connection with the client. The adoptee's fantasies of a biological connection with the therapist has already been documented (refer to Chapter 5, page 44). When both are in the position of not knowing their full history, the way is clear for the therapist to fantasise a connection with the client. This all further demonstrates need for therapist to have done their own work.

Therapist Disclosure of His or Her Adoptive Status

Some therapists make it known they are adopted and specialise in adoption issues. Others do not. What is the impact of disclosure on the therapeutic relationship? This is likely to create an expectation that the therapist will have greater understanding of the impact of adoption for the client. This creates a greater need for the therapist to have worked significantly on their own personal process and to have a good understanding of adoption dynamics. Otherwise, the scene may be set for greater client disillusionment.

When the therapist discloses his or her adoptive status this clearly has an impact on the client's projective processes and may invite a whole new range of projections (Freud 1912/1958; Curtis, 1982b, as cited in Barrett & Berman, 2001). Again, as in the family romance fantasy, with such a disclosure, fantasy may become blurred with reality. An idealising parental transference may be enhanced – finally here is the parent who understands me and knows my experience. Alternatively, if the client has a poor self-representation as an adoptee, disclosure of the therapist's adoptee status may result in the client projecting this representation on to the therapist. This may be a less helpful projection if it means the client decides not to come to see the therapist, or not to stay once the disclosure has been made.

There are of course situations where the therapist becomes known as someone who works with adoption issues and is an adoptee and this raises an equivalent range of issues but there is no option not to disclose. However, when there is a choice to disclose, of utmost importance is for the therapist to think very carefully before making such a disclosure, considering the impact on the transference relationship and always ensuring that he or she has the client's best interests at heart.

Summary

Much of the material above suggests it is particularly important for an adopted therapist to have explored his or her own adoption when working with an adopted client. Otherwise, he or she may be less helpful to the client than a non-adopted therapist who knows little about the dynamics of adoption. The unaware adoptee

therapist may be prone to colluding with the adoptee in minimisation, projection and denial.

Some of the issues which the therapist, as an adoptee, will need to have explored are his or her own self-representation as an adoptee, fear of abandonment and how he or she defends against this, the degree of oedipal conflict resolution and identification with the same sex parent, tendencies toward splitting, feelings and philosophy around search and reunion, and philosophy on disclosing to the client their shared adoptive status.

After reviewing the literature, it is clear that the issues of adoption are complex and there is significant value in the therapist understanding these issues. Nobody is likely to understand them as well as adoptee therapists who have done extensive work of their own issues and consequently this will make a substantial contribution to the therapeutic relationship and therefore to the therapy. Not only can the adoptee therapist empathise with the cluster of adoption issues and feelings the client has, but he or she has experience working through issues such as adoptive splitting and can assist the client in the journey toward integration.

Chapter Seven

Discussion and Conclusions

Summary

Adoptees are overrepresented in mental health settings. While there are a wide range of forms of adoption, underlying all of these is a significant experience of loss which has implications for the adopted person's self and object representations. The most commonly reported self-representations of adopted clients in treatment settings include feelings of being unwanted and therefore unwanted.

The adopted person's object representations are complicated by the existence of two sets of parents. There is likely to be a reliance on fantasy for the creation of biological parent representations in adoptees who have experienced closed adoption. In these cases, the typical 'family romance fantasy' of an imagined set of more ideal parents has some real base, the implications of which are difficulties for the adopted person in integrating feelings of love and hate. It is possible that the experience of adoption contributes to the formation of a general negative dimension in maternal representations as discussed on page 31.

There is a large body of evidence documenting the psychosocial impacts of adoption. This evidence identifies adoption, particularly closed adoption, as being connected to impaired attachment, and challenges to identity formation and the development of self esteem. These issues then have implications for the therapeutic relationship with the adoptee.

Clinical Implications and Conclusions

With the benefit of the literature I have now read, and the further work on my personal process regarding my own adoption, I now realise that the therapeutic alliance with the adoptee will be stronger and there will be greater integration of the client's split parental object representations as well the development of a more loving self representation when there is a greater focus on adoption and a more of an understanding of how adoption impacts the therapeutic relationship.

Following are several insights I have had into my work with Tracy, insights that I will take with me into my work with adopted clients in future.

Client as adoptee.

Tracy worked hard to distance herself from her feelings and correspondingly from me. I experienced Tracy as very aloof and detached, while talking about very painful material. I would have worked more on connecting her to her feelings and interpreted her aloofness in the context of her fears of rejection and abandonment.

At other times, Tracy described angry encounters with strangers in which her emotion appeared disproportionate to the situation. Tracy was displacing her anger toward her adoptive and biological parents on to people she would not feel devastated being abandoned by.

Both Tracy and I colluded in the minimisation of our separations from one another. With a greater appreciation for the impact of these separations, and more empathy towards my own and Tracy's early experience of abandonment, I would have done a lot more preparation for breaks, particularly the extended Christmas break. I might have interpreted Tracy's unconscious expectation that she would be abandoned, and knowing the inevitability of the distance that would be created between us from the break, perhaps interpreted her transference to me as the abandoning mother in this context.

Tracy seemed to be desperately searching for an idealisable maternal object, in whom she could see herself reflected. Perhaps interpreting this desperate search, and supporting Tracy to grieve the loss of her fantasised birth mother, may have allowed her to see the 'good' as well as the 'bad' aspects of her adoptive mother, and of herself.

It seemed too frightening and humiliating for Tracy to acknowledge her own wants and needs in her desire to find her birth father. There were some signs that she empathised with that little baby who was left in the hospital for ten days, "That ten days I was in hospital I was held, but there was different smells and different nurses, ten days is too long to really bond with anyone". Perhaps building on this budding empathy for that little girl might have created some space and facility for Tracy to acknowledge and allow her own wants and needs.

Therapist as adoptee.

The therapist who is adopted is uniquely positioned to identify and empathise with the cluster of experiences of the adopted client, including feelings of not belonging, tendencies to split parental objects, and the challenges to development of identity and a sense of self-worth. However, these sensitivities, if not worked through significantly in the therapist's own personal process, also pose risks for the therapeutic relationship with adopted clients. These risks include over-identification, minimisation of adoption related dynamics, or indeed not noticing such dynamics at all due to 'blindspots' in certain areas.

This places responsibility on the therapist who is adopted to explore the meaning and impacts adoption has had for his or her life before embarking on therapeutic work with an adopted person, and to be mindful of the potential triggers as the work progresses.

At the time of Tracy's therapy, I had not yet had much contact with my birth mother and her family, so I had very little appreciation of the sense of 'in between-ness' that I now have of existing between two families, not fully fitting into either. It was very powerful for me as an adopted person, to have my experience articulated by another therapist as 'with one family you have history but no biology, and with another you have biology but no history'. I felt as though I finally had words for my experience and could accept this place, and also felt met, knowing that there are other people in the world who share this experience. My sense is that not only would my recent experience have allowed me to be more empathic to Tracy's feelings of isolation, but also that she may have finally felt met, perhaps able to surrender the search for the idealisable object to merge with.

Would I have told Tracy I was adopted? Will I tell future adopted clients I am adopted? These are difficult questions to answer. Perhaps Tracy would have felt understood and known as I finally did when a colleague asked me pertinent questions about my adoption and understood the significance of the answers. To feel like two people who don't belong anywhere else, belonging with each other, is a very powerful experience of connection. I wonder if telling her I was adopted might have meant she felt understood. I cannot know.

What then, does this mean for the therapist who isn't adopted working with the adopted client? Perhaps being the 'good enough' therapist means knowing the important questions to ask, being aware of the issues the adopted person deals with, and how these are likely to impact on the therapeutic relationship.

Having considered the question of what the influences of being an adopted person are on the therapeutic relationship, the following conclusions can be made with confidence: firstly, that adoption does have an effect on the therapeutic relationship. Secondly, adoption issues are unlikely to be described overtly as the client's presenting problem and the therapist needs to hold these in mind being particularly gentle with bringing them into the relationship. Once an alliance is formed, the therapist needs to work to help the client understand the trauma of adoption and connect to the feelings associated with this trauma.

Adoptees are particularly sensitive to abandonment and so it is important to work mindfully with the separations that occur in the therapy. The therapist who doesn't understand adoption may minimise these aspects of the treatment. Therapists also need to be familiar with search and reunion processes and the potential outcomes of these such as genetic sexual attraction.

Given the above, for the adoptee therapist to be an asset instead of a liability to the adoptee client it is imperative that he or she has done extensive personal therapeutic work on adoption issues. It is also vital that the therapist thinks very carefully in each individual case about disclosing his or her adoptive status given the impact this has on the client's projections on to the therapist, and the possible enhancement of fantasies of biological connection.

One of the key considerations in working with the adoptee is that splitting of parental representations is likely to manifest in the therapeutic relationship in a binary transference with the therapist representing either the adoptive or biological parents and in the client fantasising a biological connection with the therapist. It is also likely that the adoptee will be searching for idealisable parental objects. The therapist will then experience countertransference feelings of being pulled into either side of the split and not wanting to let the client down. Given this likelihood of splitting, the object relations model is uniquely valuable for working with the adoptee in treatment.

Limitations of the Literature Review

There is a very large amount of literature related to adoption. Given limitations of space, it was necessary to exclude considerations such as group and family therapy with adopted people, the whangai process, and also the relatively new and very interesting topics of intercountry and transracial adoption. Unfortunately, these exclusions limit the value of the review for those seeking to understand the particular therapeutic impacts of these unique forms of adoption.

The review was written from a Pakeha worldview, and therefore its relevance for Maori adoptees and Maori psychotherapists is limited. A further limitation of this piece of research is that while adoption practices in Aotearoa are continuously moving toward a greater degree of openness, very little research was found on psychotherapy with people adopted through such protocols. Therefore, therapists working with people who have experienced open adoption would need to be mindful of the differences of such an experience in considering the findings of this review.

Future Directions

Perhaps the most important recommendation of the dissertation is that there is more research conducted in this area because most of the conclusions drawn had to be speculative due to the lack of quantitative studies. More specifically, the chapter on the adoptee therapist was entirely speculative as there was no research at all in this area. Studies comparing the impacts of therapist disclosure of adoptive status versus non-disclosure are warranted. Further, it may be useful to compare the outcomes of therapy for clients with adoptee therapists who have explored their own adoption with therapists who have not.

In Aotearoa, psychotherapists are now beginning to see clients in their practices who have been adopted through varying degrees of open adoption. Research on the differing effects of open and closed adoption on the therapeutic relationship is imperative in light of this.

Finally, given that this research was conducted from a Pakeha worldview, and that tangata whenua have their own unique experiences of adoption (within whangai and

Pakeha adoption), the impact of these experiences for Maori on the therapeutic relationship warrants further investigation.

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Appendix A

Bicultural Issues in Relation to Adoption

As I began considering bicultural issues in the context of adoption I wrote about my treaty obligations but I was reluctant to end the exploration there. I had an extensive conversation with Mihiteria King, a Maori psychotherapist and began exploring several ideas about therapy with Maori adoptees. However, given that it was beyond the scope of this dissertation to conduct a full literature review of Maori adoption issues I have included these beginning considerations here.

The Impacts of Pakeha Adoption Practices for Maori

In the 1960's and 70's in Aotearoa, Maori children were adopted into white families, because Pakeha social workers believed many Maori parents to be 'unfit' to raise their children. These Maori children were disconnected from family and unable to trace their biological roots until the introduction of the Adult Adoption Information Act, the consequence of which was the loss of knowledge of whakapapa, whenua, and wairua (Pitama, 1997). As described by Woods, Holland & Mansfield (1982), the voice of one Maori adoptee exemplifies this suffering:

I feel so cheated not knowing my Maoritanga, and what hurts more, is when one of the family remarks, "but you're **Maori**, you should know this and that". Who do they think I am when I've been brought up, knowing **their** family heritage? Nothing was ever said about my birth parents so I never asked. (p. 7).

For many Maori, the pain of such disconnection and alienation from not only whanau and hapu, but from Maori culture altogether, led to severe self-destructive behaviour, such as substance abuse and sometimes suicidal actions. Often, Maori would enter mental health services operating with a Pakeha western medical model, and knowledge of the client's adoption would be relegated to an almost irrelevant aspect of his or her history (King, 2007, personal communication).

For Maori, the development of identity and self worth, which are interlinked, is heavily dependent upon connection to whanau and hapu, and "such family systems therefore are imperative in the measure of Maori mental health" (Pitama, 1997, p. 74).

Discovering the Needs of Maori Adoptees in Psychotherapy

For Maori, whakapapa is very important. Not only is an individual considered to be bound to the land through their whakapapa, but it also defines and confirms one's identity, where one 'fits in', where one stands in relationship to others. This knowledge then provides information on the roles and responsibilities attached to one's 'position' in the whakapapa (e.g. tuakana/teina). When one knows where one stands in relationship to others, one can truly discover one's turangawaewae (the sense of groundedness and connectedness in tribal areas) and can learn to stand and speak with authority from that place. There is knowledge then of the people that require deference in certain situations. King (2007) suggests:

There is an order and it is about respect and Mana. If Maori don't know their whakapapa, it is challenging to stand and speak with substance. If you don't have legs you can't bind yourself to the land. You struggle to have the experience and understanding of turangawaewae. And for Maori, We're about trying to make connections and knowing how we are related to others. That's what whakawhanaungatanga is about, identifying where we are within our whanau, and hapu. (personal communication)

A Maori therapist working with Maori adoptees.

One valuable approach with Maori who are adopted is using story and metaphor (traditional and those based on the cycles of life) to connect them to the Atua (spiritual powers). A Maori therapist may be able to tell clients traditional stories about their place in the world, linking them in with something greater than themselves that will help hold them while they find their way. "We learn where we fit in. Between Atua and humankind come the animals, birds, insects, trees and fish. They are our tuakana. This speaks to why we have respect for them because they came before us. Whakapapa binds us all together" (King, 2007, personal communication).

For many Maori who have been disconnected from their culture, it is also important to find the language for self expression. Story and metaphor are a common form of communication for Maori. "I believe Te Reo (the language) is genetically inside Maori" (King, 2007, Personal Communication), whether they have grown up with it or not. Growing up in a Pakeha world with Pakeha language, Maori can be "lost for words". A Maori therapist might potentially understand that language loss and talk about its meaning for the Maori adopted client.

It has been noted that some Maori clients prefer to work with Pakeha therapists due to fear that if they work with a Maori therapist, “their personal information may be shared with other whanau members, that the boundaries won’t be as ‘tight’” (King, 2007, personal communication). If a Maori client works with a Maori therapist in the same community, it can present challenges in terms of extra-therapeutic contact. As Maori, one feels an obligation to acknowledge and greet the other. How do the client and therapist manage this in the Maori world? How can privacy and confidentiality be protected? These are things that can be negotiated but often the decision is made before this opportunity can be provided.

A Pakeha therapist working with Maori adoptees.

As a Pakeha therapist working with Maori adoptees, it is important to have an understanding of bi-racial placement and the different issues and dynamics that arise as a result of this, such as claiming a racial background that has been lost. It is necessary to have some knowledge of what it’s like to not have access to knowing ‘who’ one is given the importance of identity from a Maori worldview.

When attending hui, after the powhiri (formal welcome), Maori enjoy sharing connections and identifying themselves through the whakawhanaungatanga process. If one does not know who one is or where one is from, this process can be a struggle. It would be challenging to stand up in front of everyone and say something like “I’m Maori but I don’t know where I’m from”. There can be a lot of shame associated with such lack of knowledge.

It is also important for the therapist to have an understanding of the stages of claiming an identity as Maori. According to King (2007), this involves:

Finding out who you are and what is involved in the process of discovery. How you manage yourself within your (often new) Maori family and subsequent relationships. Same for the adoptive family one grew up in – managing their comments and judgements. How are you seen and what do you see, and what sort of impact does this have? How do I find myself in this culture that I belong to, but that I don’t know very well? Do I even feel like I belong? Or maybe I do know the culture well but don’t know how to fit into it. Like there is a missing link (personal communication)

While there are inherent challenges, there can also be gains for Maori from working with a Pakeha therapist as long as the therapist is open to taking responsibility for increasing his or her knowledge through supervision, reading, talking with experts, and taking an interest in the area.

As a Pakeha working with Maori, while I am not fluent in te reo, if I was to reflect on the concept of wairua, I can say “This is how I understand Wairua and what it means for Maori”. In essence, it is important that I know who I am and hold on to this knowledge, honour it and respect it and do the same for others. I was raised in a family that doesn’t have the same vibrations as my genetic and biological one, so I am conditioned to fitting in with people who are different. It is therefore important for me as an adoptee therapist to stand firm in my turangawaewae as I support fellow adoptees in finding theirs. This is a potential meeting place for me with a Maori adoptee. As King says, “it’s about finding the connections” (King, 2007, personal communication).

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Appendix B

Client Information Sheet



A Literature Review with Clinical Illustrations

Participant Information Sheet

Principal Supervisor: Andrew Duncan, PhD.

Project Supervisor: Andrew Duncan, PhD.

Student: Jenny Hylton

School of Psychotherapy, AUT University,
Private Bag 92006, Auckland 1020

Invitation

I would like to invite you to participate in my dissertation research. I will be studying the therapeutic relationship in order to understand the process and facilitate more effective psychotherapy. Participation is entirely voluntary and your free choice. If you do agree to take part you are free to withdraw from the study at any time, without having to give a reason and you may withdraw any information you have provided up until the completion of data collection. Non-participation will not affect any future care or treatment you currently receive. There will be no costs to you for taking part in this study. There are also no financial benefits for you by taking part in this study. Please sign the consent form if you are interested in being a participant.

What is the purpose of the study?

The research is part of my studies for a Master of Health Science in Psychotherapy. Its purpose is to improve understanding of the therapeutic relationship, to further my education and training as a psychotherapist and to improve our psychotherapeutic relationship.

How was a person chosen to be asked to be part of the study?

All of my clients are being asked if they are willing to participate. If you consent then you may be in the study. Participation will involve use of excerpts from our psychotherapy in my dissertation.

What happens in the study?

I will be reading about and analysing an issue related to the therapeutic relationship and using illustrations from my work with clients in my research. The illustrations will be descriptions of interactions between us. These descriptions will come from tapes of our sessions and my notes. My understandings about these interactions and perhaps our conversations about them will be used to help explain the issue under discussion. I will use the concepts and theories of psychotherapy to further this understanding. This

work will be supervised by senior staff in the School of Psychotherapy and discussed with my fellow students in order to improve my understanding and our psychotherapy. The study will not change the focus of our work or where we meet. The study will run during 2007 unless I ask for your agreement to extend it. The tapes and notes will be held securely for six years according to AUT regulations and then destroyed (except parts which are considered part of your health record which according to health regulations must be kept for 10 years). The study will not affect the length of your psychotherapy.

What are the discomforts and risks?

There are no risks.

What are the benefits?

The research will contribute to the value of your psychotherapy by looking carefully at the process of your psychotherapy.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, you will be covered by the accident compensation legislation with its limitations.

How is my privacy protected?

Your name will not be used in the research. Any information gathered will be strictly confidential and seen only by fellow students and supervisors. No material which could personally identify you will be used in any reports on this study. If necessary descriptions may be changed to protect your anonymity.

Costs of Participating

None

Participant Concerns –

Please ask me any questions you have about the project and take any time you need to consider this invitation.

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Consumer Advocate:

If you wish to talk to a consumer advocate for any reason you may contact the Health Advocates Trust, Ph 0800 20 55 55.

Re-Approved by the Auckland University of Technology Ethics Committee on 27th April, 2004, AUTEK Reference number 02/33.

Client Consent Form

Consent to Participation in Research

Title of Project: **A Literature Review with Clinical Illustrations**

Principal Project Supervisor: **Andrew Duncan. PhD.**

Supervisor: **Andrew Duncan. PhD.**

Researcher: **Jenny Hylton**

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered. I know whom to contact if I have any questions about the study.
- I understand that my sessions will be audiotaped or videotaped and parts may be transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way and withdrawing will in no way affect my future health care. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed except those required to be kept as part of my health record.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I agree to take part in this research.

Participant signature:

Participant name:

Date:

(A copy of this form to be retained by the participant)

Enquiries to: Dr Stephen Appel. 921-9999 ext 7199

Appendix C

The Psychosocial Impacts of Adoption

Referral Rates of Adoptees

While the majority of adopted children are within normal limits for psychological development, it is acknowledged that as a group, “they show a higher incidence of behavioural, emotional, and academic problems than their nonadopted peers” (Brodzinsky, 1993, p. 43).

Many studies have reported greater referral rates for adoptees to psychological services than their non-adopted counterparts. Dresser, (as cited in Jones, 1997) identified that adopted children were “perhaps twice as likely to present with psychiatric problems in childhood or later in life than are non-adopted children” (p. 64). A quantitative study of adoptees and birth parents in which questionnaires were completed by 218 adoptees from organised adoption groups found that 35% of adoptees and 42% of birth parents had received therapy at least once (Sass & Henderson, 2002). However, this study reported a very low response rate which highlights sampling limitations.

It has also been noted that adopted children are disproportionately represented in mental health settings. Zill, (as cited in Brodzinsky, 1993) stated that in the United States adopted children constituted between 4 and 5% of children referred to outpatient mental health facilities, while representing only 2% of the total population.

It has however been suggested that caution must be needed in interpreting such statistics. Hersov (1990) asserts that these disproportionate figures for adoptees may partially reflect differing use of mental health facilities by adoptive parents, rather than increased incidence of psychological problems. It has been proposed that adoptive parents, having more contact with mental health professionals in the adoption process, are more likely to see adoption as a source of difficulty and turn to professionals for support when problems arise.

While this may account for some of the overrepresentation of adoptees in mental health settings, it seems unlikely that this fully accounts for such significant referral statistics.

Wierzbicki (1993) conducted a meta-analysis of 66 published studies comparing the psychological adjustment of adoptees with non-adoptees. The main finding was that “the mean within-study effect size was .72, indicating that adoptees had significantly higher levels of maladjustment” (p. 447).

In a study of 175 adult adoptees, and 140 adult non-adoptees who volunteered to participate (mean age 34.4), Fischman (1996) found variations in the adoptee’s capacity for object relations and attachment which she deemed likely to have an impact on his or her adult relationships, providing evidence of a continuation into adulthood of the impact of adoption on the adoptee’s attachment capacity.

Some researchers say the effects of adoption are minimal and can be ameliorated. For example, Fisher (2001) in reviewing longitudinal studies of adoption outcomes reported on the Fergusson, Lynskey and Horwood (1995) study of 1265 children (41 of which were adopted). She commented that “difficulties in adolescence were able to be resolved with tutoring, counselling, and parental support. At retesting in young adulthood, adoptees and biological controls showed no significant differences in their psychological functioning on a range of measures” (Fisher, 2001, p. 152). However she is misquoting the study. Fergusson and associates report that adoptees show significantly more externalising behaviours than non-adoptees from two parent families. Secondly, Fisher claims these problems are ameliorated by tutoring and parental support however there is no mention of this in the Fergusson study. Consequently the evidence is very clear that adoption does create a psychological risk for the adopted person (Brodzinsky, 1990; Brodzinsky & Pinderhughes, 2002).

Psychological Issues for the Adopted Person Related to Adoption

Grief and loss.

Adoptees have significant experiences of loss, beginning with the loss of the birthmother. Levy and Orlans, (as cited in Johnson & Whiffen, 2003) propose that “a physiological and psychological attachment bond between mother and baby develops during pregnancy, intensifies at birth, and exists forever” (p. 178). These authors propose that adopted children powerfully feel the loss of this bond, and need to process their grief surrounding this loss to be able to form attachments thereafter. They suggest

that young children do not have the psychological and cognitive tools to successfully resolve these losses and tend to react in one of two ways. “They may provoke the very rejection they fear and become defiant and aggressive. Conversely, they may present as overly compliant and placating and become withdrawn and dysphoric” (Levy & Orlans, as cited in Johnson & Whiffen, 2003, p. 178).

Deeg (1989) supports this argument suggesting a “prepatterned ‘eurythmy’ of the neonate’s responses to the mother’s vocal and physiological sounds and overall biological presence”. He proposes that only the birth mother is able to fully provide for the psychological needs of the infant and that the early loss of her creates a sub-optimal oral experience. Deeg contends that “the arousal of aggression in response to this deprivation further lays the groundwork for the defensive need to split the biological parent representation” (p. 158).

To test the Stress and Coping Model of adoption adjustment (Brodzinsky et al., 1998) which suggests that adoption is inherently stressful for children because of the associated losses and stigma, Saiz and Main (2004) compared the early recollections of 30 adoptees with 30 non-adoptees. The findings identified a preponderance of grief and loss themes in the early recollections of adoptees compared to non-adoptees.

Doka (1989) contends that there are challenges for adoptees in grieving these losses, due to their grief being disenfranchised, or “connected to a loss which cannot be openly acknowledged, publicly mourned or socially supported” (p. 4). Robinson (2000) supports this notion, claiming that:

Because many adoptees are told that, by virtue of being adopted, they are “special”, “chosen”, and “fortunate”, their grief at the separation from their natural mother is denied, by society and often by their adoptive parents. (p. 128)

Therefore, not only are adoptees subject to many losses because of adoption, the grieving process has been hindered for many adoptees due to societal focus on the gains of adoption and an avoidance of the losses.

Impaired attachment and fear of abandonment.

Some authors have proposed that the losses suffered by adoptees impact negatively on their attachment capacity, and further that once an attachment is formed,

adoptees suffer from heightened fears of abandonment (Brodzinsky et al., 1998; Fischman 1996; Lifton, 1990; Silverman, 1985-1986).

A study of ‘early placement’ adoptees used the Strange Situation paradigm to assess the quality of attachment relationships in adoptive and non-adoptive mother-infant pairs (Singer, Brodzinsky, Ramsay, Steir & Waters, 1985). It was found that overall the quality of mother-infant attachment in middle-class adoptive families was similar to the attachment in non-adoptive families. This was particularly true for the intra-racial adoptions. These authors summarised that “lack of early contact per se does not place middle class adoptive families at risk for the development of anxious mother-infant attachment relationships” (Singer et al., 1985, p. 1547).

Conversely, as discussed in chapter three, research has shown that children placed beyond 6 months of age often show attachment related difficulties (Yarrow & Goodwin, 1973; Yarrow et al., 1973). Additionally, in a study of late-adopted children who experienced adoption disruption, attachment difficulties were found for children and their adoptive families one year after permanent placement (Rushton et al., 1988, as cited in Gaber and Aldridge, 1994). It would seem that the longer the child has to form attachments which then become disrupted through the adoption process, the greater the likelihood of the child suffering impairments in their attachment capacity.

These distortions in early parent-child attachments within the adoptive triad may then impact developing aspects of both intrapsychic object relations and interpersonal relationships for the adopted person (Brinich, 1995). This is manifest in the adoptee’s well documented fear of abandonment (see above).

Difficulties with the integration of love and hate.

In working with adopted children, several psychoanalysts have noted the adoptee’s difficulty in integrating love and hate (Brinich, 1995; Eiduson & Livermore, 1953; Glenn, 1985-1986; Wieder, 1977).

Eiduson and Livermore (1953) first noted the adopted child’s difficulty in the resolution of ambivalence toward his or her parents. In describing the adopted children they saw for treatment, Eiduson and Livermore concluded:

None of these children had ‘accepted’ the fact of adoption in the sense of facing [the fact] that these adoptive parents, with their good and their bad sides, are his parents, the ones with whom he is going to have to work out his own inner feelings of both love and hate. (p. 800)

Wieder (1977) in his analysis of adopted children further elucidated this struggle. He suggested that knowledge of the existence of two sets of parents produces conflicts of identification. Perhaps more of a product of the era in which he was working, Weider’s view of the adoptee’s fantasies of birth parents was particularly bleak. “Sadistic, aggressive cathexes of the images imbue them with the characteristics of killers, immoral people, freely perpetrating sexual and social crimes” (Wieder, 1977, p. 9). He surmised that the child’s “bad” feelings, particularly those created by normal aggressive or sexual urges, are linked to fantasies of birth parents and that in identifying with these fantasied parents the adoptee develops a self-representation that is equally ‘depraved’ (already said this in Object representations section). However Wieder seems to be presenting extreme cases as not all adoptees have such strongly negative self-representations (see above). This is the difficulty of using clinical material which often comes from children with severe difficulties and therefore is not generalisable to the broader population of adoptees.

Challenges to identity formation and the development of self-esteem.

The adopted child has the challenge of integrating into his or her self-representation the notion of being someone who was once given up. Hodges (1984) claims that this creates difficulties for the child’s development of self-esteem and sense of worth.

Sorosky and associates (1975) note that many adult adoptees appear to suffer from low self-esteem and at the same time to carry ‘chips on their shoulders’. These authors propose that adoptees “seem to be angry at the world which has withheld knowledge of their birthright from them. But they also feel embarrassed about their adoptive status and view themselves as “unfinished” or “imperfect”” (p. 130).

During adolescence, adoptees face the same developmental task as non-adoptees, that of developing a secure identity. However, Lifton (1979), Sants (1964), Sorosky et al. (1975, 1979), and Brodzinsky (1987) among others, have argued that

adolescent and young adult adoptees have to deal with more confusion and uncertainty surrounding identity, and therefore have greater difficulty resolving the identity conflict.

The term “genealogical bewilderment” was coined by Sants (1964) to describe the state of identity confusion in children with substitute parents. He claimed that:

A genealogically bewildered child is one who either has no knowledge of his natural parents or only has uncertain knowledge of them. The resulting state of confusion and uncertainty, it will be argued, fundamentally undermines his security and thus affects his mental health. (p. 133)

Else (1991) argues that adoptees in closed adoption are likely to suffer from such ‘genealogical bewilderment’ if they are unable to find the information they need to “complete their own personal histories or resolve the complex issues of identity which confront them” (p. 143).

Identity concerns for adoptees appear to persist into adulthood. Evidence from the few intensive clinical studies involving adult adoptees identifies that the most commonly encountered problems relate to genealogical and identity concerns (Sorosky et al., 1975). These authors assert that “the need to be connected with one’s biological and historical past is an integral part of one’s identity formation” (p. 219).

Appendix D

The Therapeutic Relationship and Associated Terms

In exploring the impact of being an adopted person on the therapeutic relationship, it is first necessary to define this unique relationship, and some of the key concepts relevant to it. As with any definition, there is no one universally accepted truth. The definitions chosen reflect the author's training and preferences.

Malan (1995) describes the therapeutic relationship:

Within an atmosphere of unconditional acceptance, the therapist establishes a relationship with the patient, the aim of which – usually unspoken – is to enable the patient to understand his true feelings and to bring them to the surface and experience them. (p. 84)

Before establishing a therapeutic relationship with a client, the therapist conducts an assessment. The purpose of this is twofold as suggested by Holmes (1995), “to grasp the nature of the patient's predicament, and a more distanced effort to calculate the likelihood of therapeutic success” (Holmes, 1995, p. 28).

Conducting a thorough assessment also assists in building the working alliance. This alliance is “the part of client – psychotherapist relationship that enables the client and therapist to work together even when either or both of them do not want to” (Clarkson, 2003, p. 8). It is inevitable that in any therapeutic journey, there will be such occasions, and at these times the therapist is reliant on the strength of the alliance to carry the relationship through to easier times.

Transference is a fundamental aspect of any psychotherapeutic relationship. Laplanche and Pontalis (1988) define transference as:

For psycho-analysis, a process of actualization of unconscious wishes. Transference uses specific objects and operates in the framework of a specific relationship established with these objects. In the transference, infantile prototypes re-emerge and are experienced with a strong sensation of immediacy. (p. 455)

The therapist uses his or her countertransference to help determine those transferences that are operating in the relationship. Countertransference can be understood as “the specific emotionally based responses aroused in the analyst by the

specific qualities of his patient” (Sandler, Dare & Holder, 1992, p. 96). These can include an infinite array of feelings from joy and pride to sadness and despair.

Once the therapist has a sense of the existing transferences, he or she moves into a period of working through. For Freud, working through represented “the work entailed for both patient and analyst, in overcoming resistances to change due primarily to the tendency for the instinctual drives to cling to accustomed patterns of discharge” (Sandler et al., 1992, p. 177).

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