Creating Kinship

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KINSHIP ALLIANCE

KINSHIP CENTER

EDMUND S. MUSKIE SCHOOL
OF PUBLIC SERVICE

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Preface

1

Sharon Kaplan Roszia

This book grows out of the collective intent of a national grass roots organization called KINSHIP ALLIANCE. This Alliance is comprised of individual professional from a variety of backgrounds including mental health, medical, clergy, education, and artists. They have joined together out of a common concern for children and families in all our communities. Our focus is to make life richer for children and their families by shifting the view from Who do the children belong to? towards Who belongs to a child? The goal is adding caring people to children's lives rather than subtracting people as children grow in our communities. This requires sorting out our traditional ideas about foster care, adoption, donor insemination, surrogacy, stepfamilies, blended families and relative adoptions.

The following is an excerpt from an article written by Deborah Silverstein, LCSW in the 1994 fall issue of KINTALK.

> …The Random House Dictionary of English Language states that Kinship is: *A relationship by nature, qualities, affinity, kin is defined as a person's relatives collectively; kinfolk, family relationship or kinship; a group of persons descended from a common ancestor or constituting a family, clan, tribe, or race; someone or something of the same of similar kind*. The key elements appear to be the relationship. Implicit in a relationship is a connection, involvement or association. Kinship relationships traditionally have been based on connections among persons based on blood or marriage. By being involved in adoptive and foster care relationships, however, Kinship Alliance members have also come to view Kinship as recognizing the interdependent connections among all peoples based on mutual caring rather than consanguinity. When Kinship Alliance members talk about Kinship, then, we are talking about a much broader concept that the use of the term "Kinship care" in child welfare services today….

In an article entitled KINSHIP: TIES THAT BIND published in *Adoptive Families of America*, May-June 1995 magazine, the authors Carol Biddle, MSW, Sharon Kaplan Roszia, MS and Deborah Silverstein, LCSW write the following:

> Kinship has many facets: a loving family, adults who care, permanence and predictability; roots to strengthen ones attachment to life; an opportunity for each child to have a fair chance at life; ties that bind; community that cares and protects; maintaining connections; and an individual's birthright. Kinship is creating ever expanding circles of connectedness.
>
> The definition of family and relatedness in our society has been changing rapidly, particularly in this century. Less than half of America's children will spend their childhood with both of their biological parents. Blended families through divorce and remarriage, gay or lesbian parenting partnerships, single parent families, adoptive and foster families are all forms of modern family life. In total there are now 28 ways to create human life including donor insemination, surrogacy and in-vitro fertilization.
>
> We see the growing evidence of nuclear family limitations in the five hundred thousand children in foster care nationally; the escalation of violence on our streets and in our schools; the uncounted faceless-name-

less people who are homeless; and the lamentable phenomenon of adolescent children who are becoming biological mothers and fathers but not creating families. Public bureaucracy serving children reinvented "Kinship Placements" to imply use of extended biological relatives as an alternative to non-relative foster care but often this means leaving young children with their poor and elderly single grandmothers without major services or support.

Although the forms of the family have changed, people are still trying to fit the new, sometimes called "alternative" family into the traditional model of the two parent nuclear family as the only "right" kind of family. For example single parent families are not considered traditional families. Roles, responsibilities, goals and expectations are dramatically different in traditional and alternative family forms. Yet children can be well cared for, protected and raised successfully to adulthood in each. If single parent families attempt to imitate two parent biological families, they may ultimately undervalue themselves or restrict their creativity and flexibility. Attempting to function under the assumptions inherent in the two parent biological family creates a falsehood that may lead alternative families to feelings of disconnection, shame, isolation, identity confusion, or alienation. Alternative families need new paradigms of support and kinship to add strength and dimension to their unique family models.

Recognizing the truth and beauty of the old African Proverb "It takes a village to raise a child", we can insert our own paradigm: It takes the commitment of many caring people dedicated to the wellbeing of a child to bring him or her safely into responsible adulthood. The essence of kinship captures the truth of connections. Children of course are not the property of adults; rather it is the adults who belong to their children. In adoption and through fostering, we understand that we can and must provide family, extended family and community support to all. No one need be alone.

Kinship is a safe haven with someone who cares about what happens to you. If a child is to thrive with joy, adventure, creativity and love of life, loving and committed kin by both birth and caring are a necessity. And, if the spirit of kinship is to be a signal for health in a community, all aspects of community governance and social systems must demonstrate support for the child in his family.

Adoption expands our understanding about families and connections. We know we do not need biology or blood to create strong, loving, permanent relationships among adults and children.

As children move through life, they can **add** to their biological family, foster family, adoptive family, and community advocates such as teachers, mental health professionals and spiritual leaders. Their lives will then be enhances and strengthened through this ever expanding circle of kinship.

Sharon Kaplan Roszia

Director, Kinship Alliance

Introduction

2

Annette Baran, MSW, LCSW

This collection of articles represents the material discussed in two separate year-long training courses for psychotherapists. Although both courses focused on sensitizing mental health practitioners to issues of adoption, the second course specifically emphasized special-needs adoptions.

Adoption, an institution as old as civilization, has never been considered worthy of study and exploration in university undergraduate courses or professional schools of psychology, psychiatry, social work, or marriage and family counseling. The small number of mental health professionals who specialized in adoption issues usually developed an awareness of its enormous emotional complexities after working in adoption agencies. Adoption slowly began to be rightfully perceived as a lifelong issue for birth parents, adoptive parents, adoptees, and their families, whom they identified as having areas of heightened psychological vulnerabilities needing understanding and intervention.

Unfortunately, most members of the triad seeking psychotherapeutic treatment, regardless of modality, found their adoption issues were treated by most therapists as unimportant and of little interest. Regionally and nationally, the few "adoption issue enlightened" psychotherapists, meeting at conferences, shared their difficulty in making referrals and locating colleagues who had knowledge, experience, and understanding in this area. Out of this frustration, Sharon Kaplan Roszia and I developed the first experimental course. Our prototype utilized lectures, discussions, audio tapes, articles, and a few guest speakers. A federal grant made the second course and this publication possible, with a broader, more representative enrollment, bringing in experts from all over the country to discuss issues relating to special-needs adoptive families.

The goal of both courses was not only to enrich the clinical and experiential knowledge of the professional group who attended the all-day once-monthly sessions, but also to energize them to start their own groups and train more professionals who would ultimately provide a referral base within a number of communities. It is hoped that this book, and the related audio tapes and video, will enable professionals in all parts of the country to design their own groups, increasing the number of "adoption issue enlightened" psychotherapists and eventually resulting in a nationwide referral base.

The reader will find the articles in this book are diverse in content and style. Some are lengthy and academic; some are brief and factual; some are primarily outlines or bibliographies; some are informal and anecdotal. They truly represent the variety present in both classes and were not altered for purposes of publication. It is hoped that this may offer a choice in setting up a training program, or permit the course to include differences. We who have helped to put this book together are very aware of some of the omissions. They could not be overcome with the time limitations imposed. We regret that we do not have specific articles on the African-American, Native American, Non-Japanese Asian adoptions experiences. Also not available were articles on single parenting, or the effect of special needs adoption on the marital relationship. Perhaps at another time, another publication will include all of these and many more to further illuminate the world of adoption for the benefit of the mental health profession.

Acknowledgements

We wish to acknowledge all the presenters, writers and class participants whose contributions to this project offered a chance for each of us to learn more about the field of adoption and kinship.

Infertility and Adoption

3

Kris A. Probasco, A.C.S.W., L.S.C.S.W.

Editor's Introduction

The following collection of materials by Kris A. Probasco deal with the impact of infertility issues on adoptive parents. The discussion begins with "Emotional Aspects of Infertility," an outline of the emotional process couples go through in discovering, treating, and coming to terms with infertility. This background information on infertility provides a foundation for the article, "Developmental Understanding of Infertility and Its Impact on the Adoptive Family." This central discussion is followed by a "Guide for Prospective Adoptive Couples," with Therapists' Introduction, which provides practical materials to use in working with infertile couples seeking to adopt. Bibliographic resources on the subject are included among "Additional Resources" at the end of this volume.

SECTION 1

Emotional Aspects of Infertility

I. Typical Infertility Patient
- Age 30+
- Married 5+ years
- two careers—philosophy of work hard to get what you want
- first crisis—loss ranks equal with death in one's family

II. Passage Through Infertility

1. Awareness
   - identify with fertile couples
   - decision of what time of the year to have a child
   - ask questions of other pregnant couples or parents of what experience is like
   - as a pregnancy is not occurring—it may take longer than we thought, a pregnancy anytime of the year will be fine
   - usually after a year of effort—"Are we doing everything we can?"
2. Reality
   - gain the facts; 1/6 of the married population has infertility difficulties and 50% of that population will be assisted by medical intervention to obtain a full-term pregnancy; 40% male factor, 40% female factor, 10% combine female & male factors; 10% unknown factors
   - medical intervention
     - causes
     - diagnostic testing—should be completed within 3 to 6 cycles
     - treatment

3. Life Crises
   - physical, medical, emotional, psychological, sexual, financial, and spiritual crises
   - effects as individual, as couple, their extended family, and friends
   - sense of loss—a great deal of guilt and shame are expressed
   - the whole world is pregnant—"What is wrong with me? What did I do wrong? I am different than others."
   - isolation — the pregnant world is too difficult to face
   - dilemmas
     - choices
     - decisions
     - ethics
     - moral
     - martial
4. Hope & Determination
   - education—"We are going to be successful." (but just in case, a lot of couples put their names on adoption waiting list, at this time)
   - seek support from the infertile world, perhaps join support groups (Resolve, Inc.)
   - share with the fertile world, quickly learn to edit what information is shared
   - receive their myths as:
     - relax and you will get pregnant
     - take a vacation
     - do you need some lessons?
     - adopt and you will get pregnant
   - treatment—"At least we are doing something, we want no regrets in later years."
     - fresh feelings
     - high energy
     - enthusiasm for treatment
   - selective perception—filter out negative information—a sense of "We can solve this."
5. Immersion
   - use normal coping—"If we try harder, it will work."
   - intensifying treatment—what can I do up to assisted reproductive technologies
   - resolving infertility becomes major goal-addictive behavior
   - loss of control
   - describe lives as disruptive and stressful, "How can I relax? I count every day according to the cycle."
   - infertility is central to identity: women are focused on pregnancy and birth loss; men are focused on genetic loss
   - more highs and lows, on the roller coaster
   - outward channeling of feelings—"Why her and not me? They don't deserve children."
   - inward—depression
   - heightened sensitivity to others and comments
   - lives on hold
   - seek support groups—for expression and validation of feelings
   - some start thinking more about parenting — a sense of I've done all I can, time to get on with our lives, look seriously at alternatives such as adoption and third party reproduction. Some risk of moving to alternatives too soon before grieving losses
6. Spiralling Down
   - high anxiety/low energy
   - overwhelmed with treatment — usually in high-tech reproduction, may return to hope and determination but with failed cycles quickly return to low feelings
   - losing control over emotions
   - sense of failure effects self-esteem and self image
   - isolation/avoidance
   - counseling
7. Letting Go
   - thoughts of letting go, from "There is no reason why I shouldn't get pregnant" to "I'm not really hopeful that I will get pregnant."
   - journal writing—to document thinking and feelings, looking for feelings of not continuing treatment
   - normalizing life, participation in physical and social activities other than treatment, more couple fun time, "I think we forgot how to have fun."

- expect different response / timing for husband / wife
- when enough is enough, discuss medical stopping and emotional stopping; "What if I do one more cycle, more chance I won't get pregnant."
- decisions, place us back in control
- life is not fair, this is one of lessons in life

8. Coming to Peace
   - grieving the losses, letting go of the shame and guilt
   - ceremonial recognition of the losses — making the loss tangible
   - efforts to say goodbye
     - journal writing
     - poetry
     - donation to charity
     - planting — tree, flowers
     - religious event
     - gathering of friends
     - couple retreat
     - volunteer
   - re-commitment to the marriage, "Knowing what I know now, I'd choose you again."
   - identity—"We are an infertile couple." Self-esteem no longer connected to ability to reproduce
   - intimacy—a sense of who we are moves us to love ourselves, a thermometer of how our losses are being managed
   - mastering control, validation of feelings
   - entitlement to make choices—now have more energy to listen and process education about adoption, donor conceptions and childfree living
   - *Developmental Process* bitter / sweet experiences and feelings are part of the coming to peace; "I can now manage the feelings connected to the loss."

Example

Burial

by E. Van Clef

Today I have closed the door of the nursery
I have kept for you in my heart.

I can no longer stand in its doorway.
I have waited for you there so long.
I cannot forever live on the periphery
of the dream world we share, and you
cannot enter my world.

I have fought to bring you across the
threshold of conception and birth.
I have fought time, doctors, devils and
God almighty.
I am weary and there is no victory.

Other children may someday live in my
heart but never in your place.

I can never hold you. I can never really
let you go. But I must go on.
The unborn are forever trapped within the
living but it is unseemly for the
living to be trapped forever in the
unborn.

My infertility resides in my heart as an old friend. I do not hear from it for weeks at at a time, and then, a moment, a thought, a baby announcement or some such thing, and I will feel the tug — maybe even be sad or shed a few tears. And I think, "There's my old friend." It will always be a part of me…

Barbara Eck Menning
Founder — Resolve, Inc.

SECTION 2

Developmental Understanding of Infertility and Its Impact on the Adoptive Family

Infertility is a crisis that affects one physically, medically, emotionally, psychologically, financially, spiritually and sexually. It is an individual crisis, as well as a marriage crisis and one that affects the couple's extended support systems. Once the foundation of fertility is shaken and bruised, feelings of inadequacy, being out of control, poor personal identity, sexual self-image and low self-esteem exist. As couples strive to heal their wounds connected to infertility, they must understand that this is a process, and as with all losses, will be maintained for a lifetime. This is perhaps best said by a statement written by Barbara Eck Menning, founder of Resolve, Inc., "My infertility resides in my heart as an old friend. I do not hear from it for weeks at a time and then a moment, a thought, a baby announcement or some such thing, and I will feel the tug, maybe even be sad or shed a few tears and I think 'there's my old friend, it will always be a part of me.'"

When couples come to the place of an adoption decision and have already experienced many months, and perhaps years, of effort to bring children into their family, they will have many losses. How they have effectively grieved these losses will have an impact on their adoption experience. Adoptive couples will have a fear of failure and will also have a sense of dual loyalty between the dream child and a child brought to them by adoption. The therapeutic work that is best accomplished at this stage of the adoption parenting decisions is to come to a peaceful ending and place their dreamed/loved/hoped — for child to rest. Couples need to be given permission to recognize that the child they have been working for has existed for them for many years. This child was part of their childhood play when they were pretending to be mommies and daddies. This child existed in their decision to become parents. This child existed in the love in their marriage. It also existed in their own image and identity of themselves. Putting these feelings to res is a very painful experience, but at the same time does complete a parent's responsibility to take care of their child and themselves in the process.

The planning and performance of some type of ceremony of closure can be helpful. Couples invest in different ways in designing a ceremonial event. Some write poems to their children, some write tributes, some donate baby items in the child's behalf to charitable organizations, some have a funeral ceremony or a religious ceremony. It needs to be tailored to the couple's needs and also to the individuals within the couple. For some couples it may be more necessary for one of the partners to ceremonially express grief than the other. It is important that both be supportive of the other's way of demonstrating his or her love and loss. One of the most significant ceremonial events I know of was described to me as follows: For nearly six years, a couple tried to bring children into their family. The years of infertility treatments did not result in pregnancy. The couple desired to move toward adoption, but at the same time knew that the recognition of their love child would be an important transfer for them. They saw it as helping to build a bridge to their adoption choice. The couple wrote a tribute to the love child, explaining all they tried to do in order to bring the child into their home. It was now time for them to put their unfulfilled dreams in a peaceful place. They enclosed the tribute in an envelope along with their own baby pictures. They chose to plant lilac bushes in the memorial gardens where their niece was resting. They placed the envelope in the earth as they planted the lilac bushes. They both expressed a tremendous validation of their desire for this unborn child, and their recognition that this child would not be part of their lives. They then acknowledged they could become parents through adoption. In further contact with this couple, they have stated this ceremony was particularly helpful. As daily reminders of their infertility occur, they can go back to this experience and realize they have done everything they could to come to a peaceful ending. This kind of experience can be encouraged at any time an adoptive couple perceives the need for this recognition.

As therapists, it is important to educate the adoptive couple about the continued work necessary in managing the losses associated with infertility. There will be developmental reminders of the infertility experience throughout the adoptive family's lifetime. Feelings of inadequacy and low self-esteem, and identity struggles will be present. These issues are the responsibility of the adults to

deal with — to understand this is part of the loss connected to their infertility. Some developmental guideposts in families include: the adopted child's arrival with happiness that the parenting experience is beginning, but also, with sadness in the acknowledgment that this is not the child the couple had hoped to bring home; the child's developmental progress and striving for independence; talking about adoption; talking about sexuality; continued physical symptoms of infertility; menopause, the end of any fertility hopes, occurring at the same time a teenage child becomes alive sexually, and the recognition that grandchildren still don't look like the couple. All of these events can range from a mere recognition of the loss to extreme sadness. Again, it is the responsibility of each parent to manage these feelings and seek assistance if necessary.

There are some signs that clinicians can be aware of as they work with adoptive families which may indicate whether infertility issues are being managed or are having a negative effect on the family.

1. *Definition of self*. If being a parent is the first description of self rather than human being, daughter, son, child of God, wife, husband, employee, friend, then one would suspect that there are high expectations placed on the child, and the parents may depend on the child for their own self-image.
2. *The acceptance of differences*. Does the couple recognize the child's birth heritage and the connections the child has to the birth family? Are they able to express how the child is like them and not like them? Do they describe their family to others with pride even though there are many differences within their family? The couple should acknowledge the additional tasks of adoption parenting, and be able to distinguish between their dream child and the child they are actually parenting.
3. *Level of anxiety over independence*. If parents are living in a protective state and have many fears regarding their child's independence or desires to know about his or her birth family, their fears of rejection, of being left behind, and wanting to hold the child back from his own development of self, are signs of continuous loss associated with the parents' infertility.
4. *Ability to discuss sexuality, give sex education and help children to understand infertility and fertility choices*. The parents must be able to give their child an understanding of the many choices that can bring children into a family, including parents who can give birth, but are not able to provide for their child, and parents who cannot produce a child, but want to be parents. There are parents who can produce and parent children, and also couples who choose not to be parents. Giving examples within their own community and family will be helpful to the adoptee.
5. *Issues of entitlement versus ownership*. In hearing about the parent/child relationship, a clinician needs to look for a description that demonstrates an entitlement to parent, rather than ownership. With entitlement one will see and hear claiming behavior; they feel deserving and qualified to parent, have self-confidence in their parenting skills, and unconditional love for their child. They love the child for better or for worse. If ownership is an issue, one can see and hear parents indicating that the child belongs to them as their property or possession. Do they control the family with conditional love? "I love you only if you make me happy." "I love you only if you have the proper behavior and only if you do not remind my of my losses." The amount of entitlement parents feel can be determined by the extent to which they take risks with their children, how they deal with separation, handle discipline and discuss adoption with their child and others.

Clinical intervention with adoptive families around the couple's infertility issues is very important. Because the infertility may have had years of shame and fear associated with the loss, a clinician needs to go gently and slowly in gathering family history and understanding how the family came to the adoption choice, and how they have come to peace with their infertility struggles. The goal of the intervention will be to reach an understanding that neither the parent nor the child is responsible for each other's losses. The adoptee is not responsible to cure the infertility. The adoptive parent is not responsible for the loss of birth parents. Accep-

tance of who they are and the love that connects them can be a very powerful experience.

SECTION 3

Preparing Couples for Adoption

Introduction

With one out of six couples experiencing infertility, many couples are looking at adoption as a method to build their family. The average adopting couple is over the age of 30, married 5-plus years, experiencing infertility, and desire a young child to be part of their family. Many have been frustrated for years in their medical treatment and want to become parents.

For some, the urgency to have a child may lead them into adoption plans before they are prepared for adoption parenting. Adoption is much more than the placement of a long-awaited child. It is a lifetime experience for the adoptee, birth parents, and adoptive parents. Adoption brings parenting entitlement for the adoptive parents. For those preparing for adoption, many factors need to be considered in working towards building their family.

The accompanying *Guide for Prospective Adoptive Couples* outlines some factors to consider when preparing for adoption.

At the end of this process, your clients should be able to describe clearly the type of child(ren) they are desiring/accepting as to: age range; ethnic heritage(s); and genetic history factors; medical, social, and/or mental factors. You need to understand your state's requirements for social work and legal services and all possible financial obligations, and to assist your clients as they decide on what relationship(s) they are open to with the birth family.

Adoption is a wonderful way to build a family. Adoptive parents have the pleasures of being a day-to-day parent and experience the joy and challenges of parenting. They provide their child with opportunities to develop their strengths, talents, morals and unique sense of self. These suggestions will help adoptive parents be more prepared.

SECTION 4

Guide for Prospective Adoptive Couples

- **Discuss issues of when enough is enough with infertility treatment.**

  Can you say that you have tried all that you are emotionally, physically, medically and financially able to do? What are the blocks to thinking about the adoption alternative? Does love come best when there is a biological connection? What about marriage? We are bonded and attached without blood connection. Start to think of adoption as a marriage.

- **Transfer energy of infertility treatment to adoption planning.**

  Both infertility treatment and adoption planning take a great among of time, energy, emotion and finances. Actively pursing both at the same time is asking a lot of yourself.

- **Do you as husband and wife mutually agree that adoption is the best choice?**

  This is a decision that will be made individually and as a couple. One partner may be ready before the other. It is wise to proceed when both are ready at the same time.

- **Do you accept that the dream, love and fantasy child that you have been working for through infertility treatment is not the child that you will be receiving in the adoption choice?**

  This acceptance requires a grief process in coming to peace with infertility. Adoption is not the cure for infertility.

- **Recognize that adoption is a different path to becoming parents and adoption parenting brings about additional parenting tasks.**

  Issues with birth, genetics, heritage, identity, loyalty and search and reunion will be part of your family. The child joins the family through the adoption process with their own unique beginnings and histories.

- **Go public with your decision to become parents by adoption.**

  Feel proud of your choice to adopt. Be prepared for questions from the outside, especially concerning your reasons for the adoption choice. You will be pleasantly surprised that many will share how their life has been touched by adoptions. With over 5 million adoptees in this country, many families know about adoption experiences.

- **Investigate adoption alternatives, which include licensed child-placing agencies, private/independent and international adoptions.**

  Each choice is different in requirements and arrangements. Read books on adoption and parenting issues. Talk to others that have adopted. Attend community education meetings about adoption issues. Join an adoption support group. Seek the advise of an adoption counselor and/or an adoption attorney. If you are not able to locate an adoption specialist in your area, contact your juvenile/family court for a referral. Your local Resolve (infertility support group) will also be valuable in providing referrals and contact with others that have been on your journey.

- **During your education process, you will learn about openness in adoption.**

  You will be making decisions about your relationship with the birth family. There are many types of open adoption arrangements. Get a lot of information before you make decisions. You will find that most adoption professionals support open communication and honesty in adoptions.

- **Transfer feelings of sympathy — the sorrow that you feel in the experience of infertility — to feelings of empathy, being able to acknowledge and understand birth parents' decisions and needs, as well as empathy for the child's interest and need for the birth family.**

  Be able to put yourself in their place, and ask what your needs would be?

- **Be conscientious to nurture yourself and maintain a fertile marriage.**

  A good sense of humor will also be very helpful!

- **For further study:**

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The Psychology of Donor Insemination[1]

4

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Donor insemination (DI) has been utilized mainly by couples for whom the cause of infertility is male-related. Sperm obtained through masturbation by a fertile male is placed in the reproductive tract of the woman at the time of her ovulation. We have had close to a century of experience with this type of technology. Brought into existence by researchers in the field of animal husbandry, it is the oldest and most widely practiced alternative method of achieving pregnancy for human beings. The ability to utilize the sperm from one prize bull to produce scores of cattle herds was a boon for ranchers. It is interesting to note that genealogical and medical data for bulls are carefully kept and highly valued, as contrasted to human sperm, where records are often destroyed and information denied. For humans, the procedure remains the simplest, least expensive, and most democratic technique. Until recently, DI was principally reserved by the medical profession for the wives of sterile males within a marriage relationship. Women whose husbands had poor genetic histories or had undergone vasectomies were also candidates.

Today, however, we are beginning to see an increasing number of single women and lesbian couples achieving pregnancy through DI. They may choose either to use the traditional medically sanctioned route or to employ a self-help approach, with support from their own networks. They have already changed the prevailing emotional climate and altered opinions by their own open attitude. They are challenging old institutions and raising difficult questions.

The donor offspring within nuclear families were not expected to ever learn about their conception. If they did find out, it was usually accidental. It can be assumed, however, that the donor offspring of single women or those coparented in lesbian partnerships will be told of their donor conception. Since most of these children are still too young to provide us with information, we can only try to predict what the emotional effects may be.

The rate of donor insemination has increased steadily year by year, but because of the secrecy practiced by the physicians involved, we have no hard figures on the number of donor offspring in this country. There are many estimates, none of which are reliable, and they are probably lower than the true figures. Donor sperm is readily available; donor insemination is simple to administer. It is not only the specialists in infertility who are able to inseminate patients. Every general practitioner in every small town can easily become an expert. Little thought has been given to reporting the number of cases. In fact, the opposite was and continues to be true: The thought is clearly of *not* reporting or making public the existence of donor-insemination cases in a physician's practice. Records of donors or of women who have conceived through donor insemination are either nonexistent or purposely destroyed.

Occasionally throughout the past decades, negative publicity has surfaced. For example, in a contested divorce, a husband would admit to being sterile and would accuse his wife of having become pregnant without his consent, using donor insemination. The husband would sue his wife to avoid having to support their legal child, insisting that the child was not his genetic offspring. While these cases were few and far between, they made good copy; but they failed to result in widespread dis-

[1] From *Lethal Secrets* (1993), by the authors, 1993, New York: Amistad Press.

cussion or evaluation of donor insemination. They have, however, pointed up the legal confusion and potential problems inherent to the world of DI.

Technological advances in the past decade, beginning with *in vitro* fertilizations, captured the imagination of the public. They also focused interest on the large number of infertile couples and the need for new methods to help them achieve parenthood. Despite our overpopulation concerns, there was a beginning recognition that the time might come when we would be equally concerned with the high percentage of infertile human adults. All of the potential high-technology methods of conception made news, and the media wrote and spoke extensively about each new development. This finally brought donor insemination out of the closet. In its new form, DI was not only used to impregnate the wife of the sterile partner, but also to impregnate the compassionate fertile woman willing to carry a man's baby for the purpose of giving it to that man's infertile wife. Thus the surrogate mother became part of the parenthood package, raising a whole new generation of dilemmas—ethical, legal, and psychological.

The century-old practices of secrecy and anonymity have bred a complex set of problems within the fabric of the DI family. We are convinced that in all DI families, the need to maintain secrecy and anonymity has had an adverse effect upon all of the members.

Even under the most optimum of circumstances and in the closest of families, the presence of secrecy creates dilemmas. The parents in a DI family live with lies and deceptions, which continually need to be reinforced with more lies and deceptions. Friends and relatives, particularly those of the infertile husband, looking for inherited characteristics in the donor offspring, add further burdens and pressures. Consequently, the nongenetic father's extended family unwittingly often becomes a source of irritation and anxiety to the parents.

Whenever a family lives with a secret, the fear of revelation of that secret is a spectre that haunts those holding the information, ultimately straining their relationship. Almost all of the donor offspring whom we interviewed had learned the truth of their origins in a punitive manner, when their parents' relationship began to disintegrate.

In our interviews with the parents of donor offspring, we inquired extensively about their approach to secrets in other parts of their lives. They were candid in describing discomfort and uneasiness with secrets in general. It is interesting that they were almost unanimous in identifying themselves as people who did not lie well, who were impelled to be honest in their relationships, and who basically abhorred deception. However, where the husband's sterility and the use of donor sperm were concerned, they had been indoctrinated and instructed by medical personnel never to divulge the truth to anyone. This fear of ever telling the truth deprived some families of the opportunity to seek adequate help for their problems. Even in so-called confidential environments, they tended either to lie or to in some way avoid revealing the truth about the donor insemination.

The question might be raised, "If a person never knows about having been conceived through donor insemination, how would he be harmed?" That person is harmed in many subtle ways. The parents' conspiracy of silence affects their relationship, which in turn has an impact upon the child. The parental roles shift, and the mother may assume greater authority over the offspring because she is the sole genetic parent. As a result, the nongenetic father may feel less able to parent and to set limits, causing the donor offspring to be deprived of full parenting by his legal father. The donor offspring may internalize the anxiety of his parents and feel somehow responsible for it, and unworthy. From a moral or ethical perspective, each individual should be entitled to know the truth of his conception and his genetic heritage. Essentially, donor offspring are a deprived group who are denied access to information available to the rest of the population.

It is easier to formulate theories and ideal solutions than it is to outline concrete methods of giving complicated information. However, it is important to address these issues, to deal with the problems realistically, and to find adequate solutions. How and when do you tell donor offspring the truth?

Adoption has taught us a great deal about the need for openness and honesty in family relationships. There are similarities between DI and adoption. In each kind of family, the infertile parent must first explore and then accept the loss of being

able to produce offspring. To grieve for the inability to create life and to mourn for the child, or children, that will never carry one's genes is necessary. Donor insemination cannot cover up the handicap; it is a viable solution only after acceptance of the handicap is achieved. If the grief is not successfully resolved, it is difficult for the legal father to understand the donor father's role in the child's life.

Adoption and DI have been shrouded in secrecy for many decades. The secrecy has been lifted from adoption, but many adoptive parents still deny the importance of the birth parents' role in the adoptee's life and self-concept. DI is still a secret institution, where the donor father is totally denied in all aspects. Once DI is no longer secret, once the donor is no longer anonymous, the significance of the genetic origin will take its rightful place in the donor offspring's life.

There are also differences in the two institutions that make the imparting of information dissimilar. Adoption is a concept that young children can usually understand. In its simplest form, it can be shared with the child at a relatively early stage of development, usually between five and seven years of age. Donor insemination, on the other hand, is more highly technical and needs to be explained at an appropriate time; it is closely allied to the early understanding of sexual reproduction and intercourse. Donor insemination as a concept is outside the comprehension of any child younger than nine or ten years of age. For some children, the ability to understand it will be closer to adolescence. For others, disclosure may be more appropriate at the time of young adulthood.

Children's sophistication and capacity for conceptualization vary greatly from family to family and from culture to culture. There is no single rule about the age of disclosure; telling must be geared to the individual child and his family. Although it is possible that there are very young children who could understand reproduction, it is better to err on the later than on the earlier age for telling. If the parent is comfortable in the disclosure of a donor father, a positive feeling about the information will remain, even if the facts are not completely comprehensible to the child. All children need to feel that they are normal and that they are accepted within their families, and this includes donor offspring.

Although donor offspring will not be told of their conception and genetic makeup until at least a decade after their birth, growing up in a climate of openness contributes to healthy familial attitudes and relationships. If the parents no longer live with sealed lips and the outlook of a lifetime of secrecy, they are better able to proceed with the telling of the truth at an appropriate time. In this way, they provide the child with a sound emotional climate from the outset.

We feel that a primary objective is to take the concept of insemination out of the laboratory and to impart the necessary human quality to the giver of the sperm. Therefore we must start with the donor and his role. No more anonymous donors or mixed sperm for insemination means that we eliminate the reservoir of anonymous and mixed sperm in sperm banks. All sperm must be received from known volunteers who agree to share total identifying social and medical information. The donor must agree to be available on a lifetime basis as the genetic parent. This implies updating information, permitting contact with (or on behalf of) the child, and accepting responsibility as an important genetic link for the child.

There are two basic types of DI families to consider in relation to the how-and-when-to-tell question: 1) the nuclear family, with a father and mother initially living together, and 2) the families of the single woman and the lesbian couple. In the nuclear family, the child is born within the marriage and nurtured by two parents. He assumes himself to be their child and moves through the early stages of development asking the appropriate questions, which require the answers that any nondonor offspring would receive. The difference arises when the donor offspring becomes old enough to learn about reproduction, conception, and sexual relationships that result in pregnancy and childbirth. Most children who are comfortable in talking with their parents about special information tend to personalize the facts and relate them to themselves and their families. It is not unusual for a preadolescent child to ask parents if the father's sperm fertilized the mother's egg to produce him in the way he learned about it in his health class.

Unfortunately, the child often does not give his parents ample opportunity to prepare answers. These kinds of questions are sometimes posed at awkward times. We are not suggesting that the parents must explain this personal and private family information immediately. However, we are advocating that parents be prepared for the inevitable questions and set aside time for quiet and comfortable discussion.

The question is a sexual one for the child, and he wants validation from his parents that he is their child. The donor offspring needs to be reassured at the time he is introduced to the concept of reproduction that he has a donor father somewhere in the picture. We feel that it is appropriate for the father to let his child know that he was and is sad that he could not be the child's genetic father. He understands that the child may also be very sad to learn that his father is not his genetic father and that he has a donor father. Both father and child can then share in feelings of loss. There is no way to avoid pain or discomfort in this revelation. It is not only appropriate for father and child to confront the issues together, but also proper that the father aid the child in the process of understanding, accepting, and healing.

Parents often feel that their role is to protect their child from pain and suffering. We believe that this is unrealistic, and unhealthy for the child. The truth may be initially painful, but dealing with painful situations is an inherent part of life. It should be emphasized that most of the time, parents who are afraid of "upsetting" their children with the "truth" are actually more afraid of upsetting themselves by reawakening old unresolved feelings.

For many children, the initial explanation of DI will need to be as simple and straightforward as possible, because the child will be able to absorb only the broad outlines of what he is told. The three most important elements in the initial revelation are the father's fertility problem, the existence of a person, a donor father, who provided the sperm, and the reassurance of being loved. We cannot emphasize too strongly our deep conviction that every donor offspring needs to know and to feel that donor father as a human being who wanted to provide the sperm that brought the child into existence. Presenting the donor father as the real person he is provides the child with the grounding necessary to allow him the feeling that he is like everyone else. Donor offspring are normal people, not freaks; they have been conceived in the way that all human life is conceived.

A wise procedure for parents to follow is to first provide basic information and then to elicit questions. Parents should not rush to tell all, but instead, lean back and listen. Listening opens the door to understanding what it is that the child really wants to know and how much information he can handle. Some children may be overwhelmed more easily than others and may need time in which to integrate the information before asking further questions. Parents, recognizing this, can be helpful by leaving the matter open for future discussion; the freedom to bring up the subject of DI later is of great importance.

As the donor offspring grows up, his awareness and understanding of the insemination process increase. Each person is unique, and there is no formula for how and when the child's interest will wax or wane. Being a donor offspring is only one facet of life. The subject may assume more importance at certain times than at others. For example, although the existence of the donor father is a known fact, identifying information may not be necessary until the offspring is older and ready to deal with it. Some children may be intensely curious to know their donor father's name immediately; others may wait until they want to use the information for meeting the person.

What the parents know about the donor father is information that belongs to the donor offspring, although it may be many years before all of it is passed on. Unfortunately, most of the donor offspring of today have anonymous donor fathers and their parents have little information. It is also unfortunate that they cannot get further information since most of the records were routinely destroyed in the past. While telling the child of his origins with only scant information may be difficult for the parents, it is not impossible if approached with the following in mind. Parents must admit to the child that it is sad that they are lacking in information. It is important to convey to the child that they know he would like to have more and that they wish they had it to give. However, what they do know can be shared in a way that, within reason, fleshes out the

donor and gives him human qualities and characteristics with which the child can form a degree of identification. Recognizing some of the unique qualities of the child that in all likelihood were inherited from the donor may provide additional feelings of identity. All of this helps the child to feel more comfortable and positive about his donor father and, as a result, about himself.

It is less difficult to set up guidelines and criteria for future openness than it is to address the situation of the tens of thousands of donor offspring who have grown up under anonymity and secrecy. DI parents who can now accept openness are being faced with the need to explain why they did not tell the truth earlier. In its simplest form, the answer is that donor families followed their physicians' advice. Their discomfort with their secrets, and their recent recognition of the donor offspring's inherent rights, foster their decision to share the truth with their child.

To the nuclear family with an infertile husband, the donor father was never perceived as other than a donor of sperm who enabled the couple to become parents. He does not have a role in nurturing or parenting; his importance lies in the genetic and historical connection he offers the child. To complete that role, he should be available to his offspring if and when necessary.

When secrecy and anonymity are lifted from the DI family, thought must be given to the question of sharing the information with relatives, friends, neighbors, and schools. It is difficult to make generalities in this area, because families vary in the degree of sharing with which they are comfortable. Some families, nuclear or extended, are very open in all areas, while others have their own rules of privacy, even among close kin. Generally, we believe that it is not necessary to share DI with neighbors, acquaintances, schools, or non-close friends. We would compare DI information with other rather private and intimate facts that belong within the family. On the other hand, we believe that for the parents to lift the secrecy and to feel comfortable means sharing the truth with grandparents and other close family members. It is important that the parents feel at ease about the material they disclose, because their acceptance of it will facilitate family acceptance. Parents have a responsibility to educate their relatives to a new awareness and understanding of the concept of DI.

There is a fine balance between openness on the part of the parents and freedom to advertise information on the part of the preadolescent child. There is no satisfactory answer, but it is hoped that the sensitivity of the parents toward the needs of the child will help bridge the gap so that the child will know that the information is selectively shared with close friends and relatives. It is a situation not too different from that of the child who learns about reproduction at home and then tells other children about it, some of whose parents are not as openminded. Fortunately, as the child matures, this problem tends to resolve itself.

The second group for whom "how and when to tell" is a major consideration is that of the single woman and the lesbian couple. The main difference here is that in this group, it is not a secret at all. For single women and lesbian couples, the decision to use donor insemination is known to their friends, and often to their employers and colleagues. Also, the donor is often a known person, recruited either by an intermediary or by the mother herself. For our purposes, in discussing "telling," the third difference is in the absence of a father from the home. Because the donor is not usually perceived as a major parenting resource but only as an enabler, he is not generally available to the child. In addition, the unmarried woman utilizing DI is not often eager to give the donor father very much power.

We believe that the same principles regarding the donor father apply to all groups with donor offspring. Every donor offspring, whether raised in a mother-and-father home, a mother-only home, or a mother-and-female-partner home, has an innate right to have a father who is a person. Children raised in fatherless homes generally become curious about their lack when they come in contact with children who have two parents of different sexes. The child who asks, "Where is my daddy?" should receive information about that "daddy." We interviewed many single women and lesbian couples who told us that they answered that question (all of them said it arose by the time the child was three or four years of age) by saying something like, "You don't have a daddy, only a mommy," or, "You have

two mommies instead of one mommy and one daddy."

We firmly believe that those replies are not in the best interest of the child. The child does have a father, and he should not be deprived of that person, or of that part of his own identity. It is not important whether the mother wants the father in her life or not. It is important that in some positive way, the child can have a father (like everyone else) in his life. Even if the father never visits or becomes known to the child, his existence and being and personhood should be known and acknowledged.

We know that many people in the lesbian community are deeply involved in studying and writing about this subject. They feel that their problems are unique and need hitherto uncharted approaches and solutions. While this is undoubtedly true, it is also true that many human emotional needs are universal. We hope that our point of view will be considered as they continue to study these problems.

We believe that the difference between the nuclear-family group and the single-mother and lesbian-couple group in "telling" is only in the early stages of the child's development. It becomes an issue sooner in situations where there is no father in the picture. The groups merge at a later stage in the child's maturation. Single mothers and lesbian couples need to introduce the concept of donor insemination when their child learns about reproduction. This knowledge enables the child to more fully understand the role of the donor father in his or her mother's life.

We are convinced that no matter how difficult it may be to change ingrained ideas about donor insemination, ending secrecy and anonymity are in the best interests of the parties involved.

Throughout the twentieth century, the practice of DI has continued, involving ever-greater numbers of individuals. Because it has been shrouded in secrecy, it has been virtually impossible to evaluate the practice. Consequently, DI, which deeply affects many people, has never been given the opportunity to develop and to meet the genuine needs of the individuals whom it has served. We hope that a similar secrecy, anonymity, and deception will not become institutionalized in the practice of high-tech baby making.

There is great excitement in the media with each new scientific advance that enters the field of conception and gestation. With each new discovery or technique, childless individuals and couples are given renewed hope for achieving parenthood. Our studies of adoption and donor insemination have added to our understanding of the desperation inherent to the quest for a child. Individuals will go to almost any lengths and take almost any risks to have a baby. The need for immediate gratification overrides concern for the future. Lifelong implications are ignored. What begins as a desire to start a family becomes an almost irrational obsession.

Unfortunately, the media often present an unreal picture and offer false hope to the infertile person. Much of the experimentation reported is impractical and not available to the general public. Nevertheless, it must be recognized that the definition and meaning of conception, gestation, pregnancy, and parenthood are changing; new methods and their implications are raising a myriad of questions that will require thoughtful, creative answers.

Medical science has developed new techniques for saving very premature babies. The survival rate of newborns at an ever-earlier stage of fetal development is increasing. Simultaneously, fertility experts have found ways of prolonging the life of the fertilized ovum in the laboratory, outside of the human womb. Thus the time span between the viable fertile ovum and the viable human fetus is being shortened, giving rise to the not-too-distant possibility of conceiving and gestating a child in an artificial womb. This scientific engineering challenges our traditionally and universally accepted concept that children grow in and are born from a woman's body.

And there are even more-startling experiments that threaten the fabric of our society as we know it. It is thought possible that males may be enabled to carry and give birth to children; to create a womb in a man's abdominal cavity and implant a fertilized ovum is a technical possibility. Another theoretical concept would make it possible for women to clone themselves and give birth without fertilizing their egg with male sperm. However remote these methods are, they deserve mention, if only to point out

how far afield our technology is moving. Unfortunately, there is no consideration being given to the emotional and human implications of these techniques; the focus is solely on medical miracles.

The medical miracle is concentrated on fulfilling the needs of the infertile individual or couple; it allows no room for consideration of the lifelong effect upon the child. Medical science tends to see "progress" in an isolated manner, with little or no awareness of the confusion and the potential disasters that might ensue. Because science shows us that a new direction is possible, it does not mean that this direction should be taken.

It should be noted that despite the wide publicity given to alternative conceptions, the numbers of people involved are still relatively small. The numbers involved in donor insemination, however, are large, and they will continue to grow at a greater rate than that of other methods. DI is the least expensive procedure to administer, has the same rate of success in conception as that of normal sexual intercourse, and is simple to perform, requiring no special equipment. Throughout its century-old history, DI has proven to be relatively safe and uncomplicated from a medical point of view. From a psychological point of view, this same simplicity has lent itself to institutionalizing deception, secrecy, and anonymity.

Our concern lies in the rapidity with which new technologies are being developed without adequate consideration of their emotional implications. There is a close connection in the emotional effects experienced by all of the parties involved in DI, adoption, and high-tech baby making. Universal human needs for genealogical and historical connections are the same for people everywhere, no matter how they were conceived or gestated. The understanding of who we are, where we came from, and whom we connect with in our past must not be sacrificed in the name of the new era of scientific bioengineering.

High-tech baby making threatens to become "big business," with huge marketing and distribution potential and billions in profits worldwide. The business community uses strenuous techniques to merchandise hamburgers, nuts and bolts, and new perfumes, and soon new ways to make babies may well fall into the category of "merchandising." The goal of any business is to generate a good return on its investment. To ensure profitability, a high-tech baby-making industry must utilize marketing methods and promotional efforts to convince the public of excellence and desirability. The making of large profits calls for high volume, standardization, and development of chains, or franchises. A similar push for volume in the production of babies will only increase the complex legal, ethical, social, and moral questions already inherent to new reproductive methodologies.

Whether we are discussing in vitro fertilization, embryo transfer, surrogate motherhood, or donor insemination, we must keep in mind the universal human needs of the people involved and the necessity to preserve those needs. It should be noted that the more complex the method of conception, gestation, and birth, the more complex the psychological implications and emotional reverberations. We believe that being open and honest, and sharing the facts with the offspring, are universally necessary. The true facts of origins become more difficult for the child to understand and accept in high-tech baby making. For example, when an individual comes into being as a result of a mixture of egg and sperm donors, in vitro fertilization, embryo implantation, and surrogate motherhood, his lineage is obviously confusing. It becomes even more confusing when that same individual has to undergo legal adoption to finally achieve his identity. Integration of the facts and achievement of acceptance and self-worth can come about only with the sensitive help of mature, thoughtful parents. The age at which information is shared depends upon the complexity of the information.

Just as in DI and adoption, the parents involved in high-tech pregnancies will have to come to terms with their own infertility before they embark upon parenthood. Just as in DI and adoption, the donor parent, or parents, must be known and available to the offspring. Just as in DI and adoption, the offspring must be recognized as having another genetic parent, or parents, who are important to him.

We are on the threshold of a wholly new era of high-tech baby making that contains unknowns that we cannot even predict; in addition to the genetic and medical heredity passed to offspring in DI and adoption, we can now add gestational he-

redity as a potentially important aspect. We do not yet have a clear understanding of the gestating womb, especially when the woman carrying the fetus is not the genetic mother.

The flow of medical information must continue throughout the life of the individuals involved. Indeed, high-tech baby making is a lifelong process that does not end with the creation of the child. Although the method of creation is different than that of normal conception, gestation, and birth, the child born of high-tech baby-making technology is no different than any other human being. He will experience the same stages of growth and development as does everyone else.

Children brought into the world through these new scientific advances must be provided with the most highly sensitive professional thinking at our disposal. These individuals may be unique and special, but they are also part of the human family, which, in the final analysis, is the most important consideration of all.

Recommendations

The Donor Offspring

1. Must be accepted as having two genetic parents who are important to him; they contribute to his identity and self-concept. They connect him to his biological and historical past and provide him with information that is vital to his health and well-being.
2. Has a right to know, at an appropriate age, of his DI conception.
3. Has a right to know the identity of the donor father and his medical, social, and familial information.
4. Has a right to meet his donor father if he wishes to have personal contact.

The Parents

1. Must be accepted as the legal, nurturing, and psychological parents of their child. Their role as the rearing parents who protect, provide, and integrate the child into their extended families, both genetic and nongenetic, is of primary importance in the child's development of a self-concept and a standard of values.
2. Must accept the importance of the donor father as the genetic father of their child.
3. Have a right to complete information, including identity, on the donor father, with assurances of lifelong cooperation on his part to be available to the family and the child as needed.
4. Have a responsibility to provide their child with complete information, including the identity of the donor father, and to be supportive in helping the child integrate the knowledge.
5. Have a responsibility to accept and support their child's desire to meet his genetic father at an appropriate age.

The Genetic Donor Father

1. Must accept the lifelong responsibility he bears as a genetic parent of a donor offspring. Providing sperm for insemination carries with it the acceptance of the fact that the donor is half of the biological inheritance of the child produced. That acceptance in turn carries with it a solemn obligation to fulfill the responsibilities inherent to being a genetic donor father.
2. Must provide full and complete medical, social, and familial information to the family, and must see that it is updated throughout his lifetime.
3. Must be available to the donor offspring and his family for personal contact if necessary and desired.
4. Has a right to meet the prospective parents of his genetic offspring.
5. Has a right to be told about the outcomes of the inseminations and the number of offspring conceived and born of his sperm.
6. Has a right to request current information regarding his genetic offspring.
7. Has a right to request personal contact with his offspring at an appropriate age.
8. Has no financial or legal obligations to the genetic donor offspring.

The DI Provider of Service

1. Must accept the concept that the donor is and remains forever half of the child's genetic inheritance. This genetic inheritance is of primary importance because it provides the offspring with medical, historical, and social connections to his origins, and is an integral part of the individual's self-concept. Providing sperm for insemination, therefore, must be viewed as a serious, responsible, carefully administered and documented process, which has lifelong implications for all of the parties involved.
2. Must accept only those sperm donors who are willing to accept responsibility for being known and available genetic fathers to their offspring.
3. Must accept only those sperm donors who voluntarily, without compensation, wish to become genetic fathers.
4. Must employ the highest professional standards of medical and genetic screening of the donor.
5. Must obtain complete medical, social, and familial history of the donor.
6. Must maintain complete records of the donor and the recipients, making such records available to both parties as requested.
7. Must use only one donor's sperm for each insemination. Mixing sperm must be discontinued.
8. Must use only sperm that is known and identified with a specific donor. Anonymous sperm, currently stored, must be destroyed.
9. Must limit the donor to three offspring. This number is lower than the Warnock Commission in England of ten and the American Fertility Society of fifteen. Their recommendations were based on the fear of inbreeding and incest. Our recommendation is related to the concept that each donor should be known and available to his offspring.
10. Must accept the concept of personal meetings between prospective parents and donors.
11. Must provide the donors and families with identifying information in order to facilitate future contacts.
12. Must recognize that donor insemination is a complex process with lifelong emotional and psychological implications for the participants. Providers must be prepared to facilitate appropriate services such as support groups, individual and family counseling, as well as educational programs for the community.

Psychoeducation for Adoptive Families[1]

5

Joyce Maguire Pavao, Ed.D.

With the media focusing more and more on adoption—and usually sensationalizing it—the public's impression is often that an adversarial relationship must exist between the birth family and the adoptive family. In many contested adoption cases, it looks like neither set of parents can do what is in the best interests of the child. Most certainly, the professionals (lawyers, judges, and therapists) do not seem to understand the systemic problems for the families and the dysfunction these problems will cause the child who is placed in this adversarial arena.

Adoption can be a very positive way to create a family. It is estimated that adoption affects the lives of 40 million Americans. Given these numbers, and the fact that adoption is becoming more prevalent in the 1990s, it will be increasingly important for clinicians to be skilled in working with the unique issues that face adoptive family systems. Marriage and family therapists (MFTs) can help these complex families. They can normalize and demystify the process of adoption so that those involved can be treated honorably and be prepared to handle the related issues. Mental health professionals should focus on family preservation when possible, a preventive approach to consultation, and the welfare of the children involved.

The Birth Family

When women and their partners deal with an untimely pregnancy and the decision whether or not to surrender a child for adoption, they should be educated about all options (including kinship arrangements). Therapists should discuss with clients the kinds of adoption available and the post-traumatic effects that they will encounter over time. The pain of loss is great, but the reasons for adoption being considered indicate that parenting that child might *also* prove very difficult. Birth parents need to speak with someone in the beginning of their decision-making process. Once they've had adequate psychoeducation and counseling, then the possibility of a good and healthy adoption is secure.

Currently, birth parents often want to be involved in the selection of adoptive parents. What parent would not want to know something about where his or her child is going? Meeting the adoptive parents before a decision is made is not uncommon. Yet the trend appears not toward open adoption but toward *semi-open* adoption. In semi-open adoption, there is a one-time meeting between birth parents and pre-adoptive parents, and first names are exchanged. An emotional connection is made between both parties, as is an agreement to have the agency or adoption professional act as an intermediary in the yearly (or as otherwise decided by parties) exchange of letters, pictures, and updated medical information. Semi-open adoptions allow birth parents to feel more connected to the child they cannot parent.

Closed adoption—the traditional form since the 1930s—offers no identifying information, very little nonidentifying information, and no agreement for future meeting. Open adoptions can vary a great deal, from regular meetings to occasional written contact. In all forms of adoption, birth parents terminate parental rights, and the adoptive parents take them on. The emotional and psychological connections are never terminated.

[1]From article of same title by the author, 1995, February, *Family Therapy News,* p. 16-17. Copyright 1995 by Family Therapy News. Adapted with permission.

Pre-Adoptive Parents

Understanding what precedes the adoption, whatever type it may be, is important. A majority of pre-adoptive couples have struggled with infertility for years. The pain and loss that result from constantly hoping for a birth child and undergoing invasive medical, pharmacological, and surgical procedures (which strain a couple's relationship) make adoption seem like additional hoops to jump through to be parents. Like birth parents, adoptive parents feel like victims of the process. Pre-adoptive parents often suffer a lack of understanding by some family, friends, and society. This results in a subtle but lifelong experience of pain, guilt, shame, and loss.

The panacea, in days of old, was adoption. We now know that adoption does not fix infertility. It fixes the desire to parent, and adoption is a wonderful way to do that. But the issues of never seeing a child of "one's own" continue to exist. These issues are present for extended family members as well. (Parents of pre-adoptive couples benefit a great deal from being included in psychoeducation and counseling about adoption.)

In therapy, a 30-year-old woman adoptee clearly remembered and recounted a day soon after her eighth birthday. Louise was very close to her adoptive Mom. They were making her room into a "big girl's room." They chose flowered wallpaper and colors for paint and a lovely bedspread and curtains. The grandparents came to dinner soon after the project's completion. Mom and Louise each held one of Grandma's hands and told her to close her eyes. They excitedly walked her to the door of the newly arranged room. They flung open the door and gleefully told her to open her eyes. Grandma opened her eyes and looked all around the room. "What a beautiful room for someone else's child," she said.

This was not a "wicked" grandmother, although both mother and daughter were devastated by her comment. This was an aging mother who suffered from the loss of never seeing her birth grandchildren. Psychoeducation, even 22 years after this unforgettable day, could help the entire family. And psychoeducation *before* adoption for parents and their extended family or community will lead to more support of the adoptive family, along with a greater understanding of participants' own feelings. A marriage and family therapist (MFT) can help families discuss and make sense of these issues in the pre-adoptive process. Gay and lesbian couples and single parents who adopt will also benefit from pre-adoption psychoeducation.

Thinking about Adoption

Pre-adoptive couples and individuals are subjected to a variety of stresses that others do not experience in preparing to parent, i.e., agency assessments, home studies, processing the types of adoption that include varying degrees of openness, and having to make difficult choices with lifelong impact while lacking support and information from people who understand this process. Couples need to talk with each other honestly and to decide what will be best for them as a family *outside* the adoption professionals' arena. The process of adoption often insists that the couple presents one unified front. In fact, partners are often at different places in the process. Couples need to work on their differences in this process, preferably with an MFT who will guide them through the process and help them decide what is best for them. An overview of the adoption system will ease their plunge into an agency or professional's office.

Couples and individuals thinking of adoption would do best to understand in advance whether they want a closed, semi-open, or open adoption; whether they want to use an agency or lawyer or adopt independently (laws differ in varying states); whether they want to use a public agency or private; whether they want to adopt an infant or older child; whether they want a domestic or international adoption; whether they want a same-race or transracial adoption. The better educated couples are about what they want and what is available with each adoption agency or professional, the more empowered they will be.

For example, what degree of openness is preferred? People are quite often surprised to hear that, just as in a marriage in which the in-laws and extended families are present (like a Greek chorus) whether they live next door or 3,000 miles away, so

in adoption are the birth parents and birth families present in the lives of the adoptee whether the adoption is closed or open. (Obviously, they are more *physically* present in open adoptions.)

Other issues need to be considered in transracial or international adoptions. What connection will a family have to the child's culture of origin? In a transracial adoption, how will parents allow a child access to the child's culture and ethnicity? Will parents live in a diverse community? Will they provide role models of the child's culture or race?

A young Korean boy came home from school after doing a project on Korea and asked his Mom if she knew how many people lived in Seoul (where he was born.) She answered him. He then asked if she knew how many people lived in all of Korea. And she told him how many millions. He then sat pensively, and she asked him what was wrong. He said, "I really do understand what you told me about my birthmother not being able to care for me, but was there no one else in my whole country who wanted me?" This is the inner concern for a young international adoptee.

MFTs who offer psychoeducation to families that are considering an international or transracial adoption need to stress the importance of environment and role models. Parents should consider providing a setting that is diverse enough to create a holding environment for the child. The challenge is to help children develop their own identity within the framework of two or more cultures, birth and adoptive. This connection is essential to wholesome growth and positive self-esteem and identity. The other challenge is for the family not simply to see the child as biracial or of another race, but to see the *entire* family as a biracial family.

Brief, Long-Term Therapy

What do families need? An inclusive, systemic approach that normalizes stages of development and includes diverse family members. While the first crisis may be about the decision to adopt or not to parent, other crises often follow *after* adoption. In my therapeutic model called "brief long-term therapy," a family and various constellations (different family sub-systems) are seen during a crisis. The work then involves transforming that crisis into an empowering experience. If families come back for further therapy at a later stage of development, this is seen not as a failure. Rather it is a success in working through yet another stage of development. There is a completion of each stage of therapy but no "termination." (The word "terminate" is too loaded for those who have suffered the losses associated with adoption.) The therapist remains available for consultation and therapy. This avoids the emotional cut-off and loss that are primary issues in adoption.

MFTs are well equipped for this work. They already take a systemic view and seek empowerment over pathologizing problems. By working with *all* the family members involved, along with agencies, courts and schools as needed, MFTs can spread understanding…and healing.

Postscript—The Knowledge Base

There is no real training in professional schools regarding adoption. In social work programs, usually there is perhaps one case study. Certainly, there is nothing in marriage and family therapy or psychology graduate programs, unless someone makes it his or her dissertation. Even then, it is hard to find faculty who understand the issues and have experience in this field. In the American medical school curriculum, there are only two or three paragraphs about adoption. The American Association for Marriage and Family Therapy (AAMFT) occasionally offers one or two workshops on adoption at its annual conference. But this subject is underrepresented at all mental health professional conferences.

Adoption has been pathologized in the past. Until very recently, adoption literature has been based on the perspective that issues and responses of the adoption triad are pathological. The depression, anger, and shame of the birth parent have been seen as an unhealthy response to be conquered. The pain of infertility that adoptive parents often face is too frequently seen as a problem, especially in the realm of parenting. The adoptee is overrepresented in treatment facilities and often seen as having learning disabilities and emotional difficulties.

My research at both Antioch and Harvard University, beginning in 1978, led me to think of the normative crises in the development of the adoptive family. I have developed models for treatment and training that presume that there are "normal" developmental crises that occur in adoptive systems. Although all families and individuals go through developmental stages, the special circumstances that adoption creates add issues and complexity to the process of development. These issues are normal and healthy within the adoption context.

The normative model proposes that a systemic approach is needed to work with the adoptive family system. There is no identified patient in this model, but the whole system (from the wider context of adoption practices to the intricate relationships in the adoptive and birth families) is regarded as the client. Crises can be normal and can even lead to transformation. Clinicians must be familiar with and empathetic toward each member of the adoption circle, including the birth family, whether known or not.

A Child's Journey After Adoption

6

Vera Fahlberg, M.D.

Caseworkers often perceive placement of a child in an adoptive family as the end of their work. Although placement may signify the end of the child's sojourn within the child welfare system, in reality it is the beginning of a lifelong journey that, hopefully, will lead to overcoming the effects of whatever traumas led to the child entering the system, as well as the negative impact of experiences he or she may have experienced while in care.

Children who join adoptive families after experiencing abuse (either physical or sexual), neglect, parental separation and loss bring with them a legacy of failed family relationships. Their new family provides a new hope, and possibility, for them to experience the intricacies and benefits of family life more successfully.

Although previous life experiences may have led to emotional insults that may benefit from formalized therapeutic interventions, primary healing, if it is to occur at all, will occur within the context of day-in, day-out family life. According to Barth, et al. (1987), it is the result of the interface between the characteristics of the child and family that leads either to healing for the child or to disruption of the placement. The characteristics of the child, his or her behaviors, temperament, habits, and academic skills are important only in relation to family characteristics and patterns.

Adopted individuals may have problems that reflect the family dynamics of former birth and foster families—dynamics that may well have led to their developing a variety of survival behaviors. These behaviors may have made sense in the pathological environment in which the individuals previously lived, but when re-enacted within a healthier family environment, they appear to be very dysfunctional. Additionally, many special-needs children have a variety of individual vulnerabilities, based on genetic predisposition or prenatal experiences. Commonly, these include the effects of prenatal exposure to alcohol or drugs. These children also bring the legacies of a variety of traumatic events. Universally, they face the effects of parental separation or loss, and sometimes of multiple placements.

The adoptive parents bring legacies from their own growing-up years, events that led them to adoption, possibly their own individual vulnerabilities, and fantasies of what adoptive parenting will be like.

Jewett-Jarratt (1989) identifies several stages of commitment in any relationship.

1. Initial commitment based on incomplete information and fantasies
2. Adjustment
3. Weighing of pluses and minuses of relationship
4. Recommitment based on reality

It is particularly useful to explore these in terms of special-needs adoption. The initial commitment that the child and prospective parents make to each other is usually based on incomplete information, combined with large doses of fantasy. Adoptive parents come with high hopes about their abilities to effect change in the life of this child. They are prone to minimize the potential long-term effects of early life traumas and to believe that a positive environment can overcome anything. The young person, on the other hand, comes to the new relationship possibly with high hopes for the future, but most definitely with the legacy of failed family relationships.

Jewett-Jarratt points out that during the adjustment phase all participants in the new relationship begin to recognize what they got, as opposed to what they thought they were getting. Although parents and child may initially go through a "honeymoon" phase during which all are on their best behaviors, some form of testing behaviors usually come forth relatively soon. The youngster tests the limits of the new parents' availability and commitment. The parents, even when they expect this to occur intellectually, are likely to be unprepared for the emotional drain that accompanies it.

With the early adjustment and grief process that accompanies most placements, there will be some regression in the child's behaviors. However, the effects of this regression are usually rapidly overcome. Unfortunately, rather than seeing this for the regression it signifies, adoptive parents frequently think that they have been very effective in helping the child change and grow rapidly. Usually somewhere between seven and nine months into the placement, the effects of early regression have been mastered, and child and family alike begin to face longer-term issues, which will not be quickly overcome. Not only do the adoptive parents face the reality of the child they got, rather than the child they anticipated, but most likely they simultaneously begin to realize that they are not the people they thought they were.

The adopted child, with his or her distorted view of "normal" family relationships, is most likely re-enacting his or her internalized view of what parents and children expect of each other. The parents are confused by this re-enactment. They are functioning with a very different working model of what family life is like. Each tries to change the other's view, usually without recognizing why the other individual is behaving as (s)he is.

At this point, parents, and many adopted children as well, come to the third stage of commitment, according to Jewett-Jarratt. During this period, individuals weigh the positives and negatives of the relationship and possibly the costs of trying to change the other. Usually, the adults do this on a more conscious and open basis than the young person. All members of the relationship, knowing much more about what they are getting into, are asked to re-commit themselves to the relationship. This is when the real change process starts.

Although negative life experiences cannot be undone, positive life experiences can help to counterbalance their effects. Parents can help their children learn compensatory skills. Parents face the tasks of helping their adopted child feel lovable and capable, as well as aiding them in developing a strong, healthy identity, which acknowledges the adopted individual's origins and history, and the changes he or she has made throughout the years.

Parents and children alike may need help in addressing the effects of re-enactment and in developing strategies for providing new experiences that change the child's perceptions of healthy adult-child relationships and their own self-worth. The children may need assistance in learning to express strong emotions in more acceptable ways. Adopted children's emotional energies may be tied up in past relationships. In these situations, disengagement work may be necessary before the child will be able to make use of new family relationships. Adopted children deserve to have help and support in this area.

Adoption is not an event, but rather a lifelong experience. Kaplan and Silverstein (1988) have identified seven emotional experiences that will affect adopted individuals, their adoptive and birth parents throughout their lifetimes. These are loss, grief, control, rejection, guilt and shame, identity, and intimacy. At different points in life, stimulated by developmental changes or current life experiences, one or another of these issues will bubble to the surface and need to be addressed and readdressed. These issues are never "resolved." They will be renegotiated with each major developmental change. New cognitive skills, combined with current life tasks, lead to repeated opportunities to re-examine and reintegrate the effects of early life events on one's current adjustment. Each time this is done, the individual has more energy to put into addressing current developmental concerns, and these emotional issues will fade into the background, until another event or stage triggers their re-emergence.

Understanding developmental tasks at various ages helps us understand the impact of pre-adoption events and recognize when the longer-term effects of these events might make themselves evident, presenting opportunities for the adopted individual and family to work to overcome these

effects. There are some quite predictable ages at which adoption-related issues will interface with normal developmental progress. If adoption issues are not addressed at these times, it will be difficult for the young person to master the developmental tasks at hand.

For example, identity issues tend to surface at several predictable times throughout an individual's lifetime. If the adopted child experienced events that interfered with the original mastering of tasks associated with identity when he or she was 18 to 30 months old, this issue will resurface in early adolescence. Adoptive parents, the young person, and helpers should be prepared to concentrate energy on this issue at this time. Another opportunity will present itself at the end of adolescence, at the point of emancipation from the family.

Let us now look at a developmental overview that may help us understand the impact of some events in the adopted individual's past and their implications for his or her future.

First Year of Life

Primary tasks to be accomplished are:

1. Meeting dependency needs.
2. Building feelings of trust, security, and attachment.
3. Beginning to sort out the significance of various external and internal stimuli.

If an infant's dependency needs are not met, he or she may grow up to continue to think that life owes him or her something, and it is quite likely that he or she will have trouble ever meeting the dependency needs of others. Trust of others will be impaired. Although these problems may not become evident until ages nine to eleven, learning problems — problems acquiring a basic sense of cause and effect — may occur as a result of the infant's needs not being met. In spite of this problem having its origins early in life, the subsequent learning problems may not become evident until ages 9-10.

According to Brodzinsky et al, infants placed at birth with caregivers other than birth parents are just as likely to form normal parent-child relationships with their primary caregivers as those who remain with birth parents.

Perry (1993) notes that because of their influence on the developing nervous system, traumas in early life may have a lifelong impact on the child.

Toddler Years (1-3)

Primary tasks:

1. Gaining autonomy — a sense of independence.
2. Forming identity — sex, position in the family, and first name are all important factors.
3. Continuing growth in awareness of perception, both external and internal (e.g., toilet training).
4. Developing functional language.
5. Developing social emotions (empathy, pride, shame, guilt, embarrassment).

Toddlers whose needs are not met may permanently take on a "victim" or "victimizer" role. Long-term control issues may be prominent. A serious effect may be disruption in ego development, with an increased incidence of "borderline personality" problems. Later in life lack of self-awareness may be ongoing. They may have long-term subtle language problems. As adults, they may become rigid, inflexible, and unable to deal appropriately with aggressive impulses. Lack of appropriate development of social emotions leads to long-term problems with interpersonal relationships and conscience development.

Preschool Years (3-6)

Primary tasks:

1. Continuing individuation, independence, and proficiency in self-care.
2. Solving two major internal psychological struggles (usually through the medium of play) — "big vs. little" and "good vs. bad."
3. Continued formation of sexual identity. (Oedipal stage.)

Preschoolers' thinking is magical and egocentric. They believe wishes make things come true. They believe that all attitudes, behaviors, and emotions of others are in response to themselves. Their thinking is concrete and literal. They will "parrot" what they are told without necessarily understanding. In general they think whatever they have experienced is the norm.

Because of preschoolers' concrete thinking, adults must be very careful of the actual words they use with children of this age. Combining magical thinking and the "good vs. bad" struggle, the preschooler may perceive himself as so "bad" that he caused abuse, neglect, loss, or other negative events. Magical thinking and the "big vs. little" struggle may lead the youngster to attribute traumas to his either being too "big" or too "little," dependent upon the particulars of the situation.

Children of this age continue to view whomever is providing their caregiving as their family; they are incapable of understanding a connection to a birth family with whom they do not live. According to Goldstein, Solnit, and Freud (1973), although young children will freely love a variety of adults who feel positively toward each other, up until the middle grade-school years, they cannot maintain positive emotional ties with a number of individuals who are unrelated or even hostile to each other.

Grade-School Years

Primary tasks:

1. Mastering problems encountered outside the family unit, while using the family as a secure base.
2. Academic learning, developing peer relationships, and improving gross motor skills.
3. Developing conscience — Although it starts before this period and continues long afterward, major growth occurs now as the youngster moves from fear of consequences to internalized guilt and displeasure with self after doing something wrong.
4. Developing increased awareness of own strengths and weaknesses in a variety of areas — to do this, children of this age need opportunities to try a variety of activities.

Brain growth between ages five and seven lays the foundation for more mature thinking with the development of logical reciprocity. Up to age seven or so, children identify family as those who live together; by age seven or eight, children recognize that families are usually defined in terms of blood relationships.

At age eight to nine, most children experience a major leap in cognitive development. Learning is no longer limited to rote memory. The youngster now integrates information gathered from a variety of sources and comes up with his or her own interpretations. He or she no longer likes to be singled out; he or she wants to be "normal," which means ordinary. Not living with a birth family means being different, which has a negative connotation.

Living away from a family of origin may also be associated with feelings of rejection. According to Brodzinsky, Schecter, and Henig (1992), children who perceive themselves as abandoned or rejected are likely to be angry at their birth parents; those who think they were stolen or bought will be angry at current parents; and those who think there is something wrong with themselves that made their parents not want them will turn their anger inward.

Brodzinsky, Schecter, and Henig explain that becoming emotionally aware of having lost a set of parents prior to joining the current family leads to a process of "adaptive grieving." This grief may show itself through confusion, occasional sadness, social withdrawal, or periodic outbursts of frustration or anger. Although adults can ease the grieving process, they cannot spare the child pain from dealing with the loss of the birth family.

Children of grade-school age begin to recognize the importance of their birth father and to feel a sense of genetic connectedness to birth family members, even though they may have little or no direct knowledge of or contact with them.

They now make distinctions between mind and body, between what they thought and did. Self-concept now reflects personality factors over physical factors.

Adolescence

Primary tasks:

1. Psychologically separating—need to answer questions of "Who am I?" "Where do I belong?" "What can I do (be)?" and "What do I believe in?" To successfully complete this task, the adolescent needs to come up against and oppose parental figures, who must be consistent in their availability and behaviors.
2. Developing of self-control—During times of psychological separation, control issues tend to emerge. The adult's role is not to take control from the adolescent, but rather to create an environment in which the young person has to develop more self-control.
3. Dealing with sexual issues — Because of physical and hormonal changes, adolescents are highly sexualized (not to be confused with necessarily being sexually active) beings. They move from depending primarily on same-sex relationships to also developing opposite-sex relationships.
4. Identity issues are once again prominent. Brodzinsky, Schecter, and Henig (1992) identified different aspects of identity:
   a. Physical identity includes appearance, health, and maturation, all more related to genetic than socio-legal family.
   b. Psychological self includes personality, intelligence, and talents. It, too, is strongly influenced by the genetic family.
   c. Social self includes relationships with others; more related to socio-legal family.
   d. Achievements.
   e. Values.
5. Rapid gains in abstract thinking lead to developing the ability to reason hypothetically, to take into account a wide range of alternatives, and to reason "contrary to fact." However, according to Gardner (1982), developmental psychologists now believe that this capability exists in only 30 to 40 percent of adolescents and adults in America. Simultaneously with the gains in thinking abilities, egocentric and magical thinking tend to resurface.

Because the primary tasks of adolescence are so similar to those of the toddler and preschool years, traumas, unresolved issues, or unmet needs from that earlier period frequently resurface during the teen years. This means that many children and their families will be faced with particular challenges during this period. On the other hand, because the tasks are similar, there are opportunities for more complete reorganization of relationship patterns and more extensive healing.

In addition, because adolescence is a period of rapid growth and because of advances in intellectual development, as well as development of a variety of important relationships outside the nuclear family, this is a period when reorganization of relationships is more likely to occur than at other periods of life.

As emancipation approaches, loss issues may resurface. Those teens who left a previous family abruptly, with turmoil and minimal post-move contact, may have the most difficulties with emancipation. They will need to learn to maintain relationships with people with whom they no longer live.

Youth, defined as the period between adolescence and young adulthood, is, in our culture, a by-product of protracted schooling and prolonged financial dependence in middle-class families. According to Brodzinsky, Schecter, and Henig (1992), it tends to be a period of great introspection during which individuals broaden and consolidate their sense of self. In general, during this period, friendships become deeper, more meaningful, and more intimate. Young adults focus on career choice and achievement. A lack of information about their birth families and/or early life events may lead these individuals to feel cut off from part of themselves.

Brodzinsky, Schecter, and Henig (1992) have written that searching for birth family members during adult years has typically been undertaken by young adults, 80 percent of whom are female. It is rarely directly associated with satisfaction or dissatisfaction with the adoptive family. During these years, the young adult searcher is looking for a relation, not a relationship. Men most commonly search after the birth of their first child, and frequently undertake the task at the urging of their partner. Those adults who search when they are much older are usually trying to answer questions that have plagued them their entire lives.

As we have seen, placement with the adoptive family provides a place for the child, who cannot for whatever reasons grow up with his or her family of origin, to experience family connections that may lead to overcoming the legacies of earlier experiences. It is a beginning, not an end. It is the start of a journey into the unknown, both for the child and for all members of the adoptive family.

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Post-Adoption Services

7

Vera Fahlberg, M.D.

Special risks face an adoptive family's survival as a unit. Caseworkers can aid in ensuring the adoption's success by recognizing these risks and providing a variety of post-adoption services that utilize all the supportive elements available in the family and community.

Services for adoptive families must consider some special circumstances not found in nonadoptive families. Children and parents alike come to adoption with some added risk factors when compared with children joining their permanent family at the time of birth.

Child risk factors include:

- Survival behaviors that originated when they lived in dysfunctional families and a dysfunctional system.
- Individual vulnerabilities.
- Previous traumatic events.
- Unresolved separations or losses.

Parent risk factors may include:

- Lack of empowerment and entitlement.
- Unrecognized or unresolved losses.
- Unrealistic expectations for child or self.
- "Echoes" from their past.

Elbow (1986) identifies three factors in older-child adoption that contribute to difficulty in mastering family developmental tasks:

- Distortion of family life cycle: Adoptive families begin with distance and are expected to move toward closeness; birth families start with symbiosis and are expected to move toward individuation.
- Stress on family boundaries, caused by agency intrusiveness, lack of family's empowerment by society and agency, and child's conflicted loyalties.
- Individual issues of the child and echoes from the past for the parents.

Because of the nature of special-needs adoption, involvement with post-placement services and mental health resources should be considered a normative part of such an adoptive family's experience.

Adopted children and their families are best served when there is collaboration between the family, social service agencies, and mental health resources. Each can thus recognize not only what they, but also what others, have to offer, as described below.

The family:

- Provides the foundation on which the child's continued development is dependent.
- Provides the environment for change.
- Provides continuity and commitment.
- The fact that family members need help in meeting the child's needs does not mean that they do not care or that they are incapable of participating in decision-making.
- If the family is made to feel impotent, it is harmful to the overall treatment.
- If family members are recognized as doing the best they can in difficult circumstances and as having an important role in any change process, they can be stronger partners.

- Unfortunately, families may not seek help until they feel overwhelmed and desperate, and thus present themselves at their worst. At that time, it is difficult to make a solid assessment of the parents' long-range capacities.

Social workers:

- Know how the system works.
- Are more likely than others to know how to access information about the child's specific past history, information that may be critical to providing adequate treatment.
- Can help families locate and access the specific services they need (e.g., support services, respite care, therapists knowledgeable about adoption).
- Can provide information to therapists about common behaviors seen in "system" children.
- Predict times that will be difficult for child and family (based on developmental information and knowledge about anniversary reactions, etc.).

Mental health professionals:

- May provide assessments of families and children, both before and after placements.
- May be able to intervene early enough that they can help prevent problems from becoming entrenched.
- May help families connect with support groups.
- Work directly with children and families when there are ongoing problems.
- Provide information about when families might anticipate future problems.
- Are involved in crisis intervention.
- May help determine if out-of-home care is necessary and the level of care that would be most useful.

Post-adoptive services need to be provided by individuals who:

- Understand adoption-related issues.
- Understand the social service and legal systems and their impact on the child prior to placement.
- Are supportive of the adoptive family's role and importance in the child's life.
- Include the parents in assessment, planning, and treatment.
- Will work with parents to develop strategies for behavioral interventions.
- Will collaborate with others who are involved with this child and family (e.g, schools, etc.)

Types of Post-Adoptive Services

Post-adoptive services may take a variety of forms:

- Supportive services (groups of parents or children, respite care, training and educational services) can meet the needs of many adoptive families.
- Services aimed at helping the child and family come together soon after placement.
- Intermittent preventative therapy, instituted as children reach certain developmental levels that are likely to retrigger old issues (e.g., sexual abuse, loss, identity, etc.).
- Intermittent short-term problem-focused therapy aimed at interrupting problem behaviors.
- Crisis intervention with threatened families.

These forms are detailed further below.

Support services:

Families who were prepared for adoption using a group process frequently use other group members as an informal support system. Agencies may provide parent support groups, or help individual families connect with others who have had a similar problem. They also may provide parent education presentations. Even families who need more intensive services view support services as helpful. Respite care can be a very useful service,

but unfortunately families are frequently left to their own devices in terms of accessing respite if it is needed on a regular basis.

Initial post-placement services:

These are aimed at helping the child and family come together as a unit. The emphasis is on resolving current separation and loss issues, addressing current behavioral problems, and facilitating the attachment process. The focus is primarily on the present. According to Katz (1977), the client is neither the child nor the parents, but rather the relationship. These services should prepare families and children for identifying times that preventative work might be undertaken and times that old problems are likely to re-emerge.

Preventative work:

New cognitive skills, combined with current life experiences, will lead to repeated opportunities for reintegrating the effects of earlier life experiences. Understanding the developmental tasks presented at various ages helps professionals and family members alike to understand the impact of pre-adoption events and to make use of opportunities provided to overcome these effects. If adoption issues are not addressed at these developmental times, it will be difficult for the adoptive family and young person to master the developmental tasks at hand.

Intermittent, short-term, problem-focused therapy:

When families are faced with living with children who have disturbing behaviors, they look for therapy with goals and timelines upon which they and the therapist agree. Parents tend to abandon therapy when they are not included and when the therapy does not address the behavioral concerns that initiated the parental request for intervention.

Crisis intervention with threatened families:

Donley and Blechner (1990) identified threatened families as usually having these characteristics: There is a long-term adoptive relationship in place; there is evidence of repeated self-destructive or violent behavior by the child; these episodes of problem behaviors are intensifying; the parents may have made a variety of unsuccessful efforts at obtaining help; and the parents feel that the situation is out of control.

According to Grabe (1990), this is not the time to question the family's commitment, size, or motivation to adopt. It is a time to offer some initial relief that will help the family stay together until substantive improvements in relationships can be achieved. This will require a more complete assessment and flexibility in providing services that can help.

Donley and Blechner (1990) point out that it is very important that intervenors not mistake these families for chronically troubled families who have never experienced a period of relatively calm adjustment. Many times these are very competent parents, who may have difficulty convincing others of the seriousness of the problem. They may be more skilled than the people to whom they are turning for help, who in turn may be intimidated by the parents.

In general, these parents either did not expect the adolescent to have as severe behavior problems as are evident, or they misperceive the long-range prognosis. The family may be under a variety of stresses. The young person's individual pathology may be becoming more evident.

Intensive adoption preservation services are called for in such cases. These include all aspects of support services, including short-term out-of-home placement. The overall goal at this time is to engage the families in treatment and to help them see the problems in a realistic context.

During provision of these intensive services, it may become apparent that the young person needs out-of-home care. It is important that this be provided in a timely enough manner that the family continues to be available as a long-term resource for the youngster.

Limits of Traditional Therapy

Traditional therapy approaches alone have not been particularly successful with the special needs adopted children population.

Individual non-directive therapy with the child:

- Frequently never addresses the issues of abuse or neglect if the child does not introduce these topics.
- Rarely focuses on the behavioral issues that ultimately will determine whether the child remains in the placement.
- Tends to disempower the family and distance them; does not focus on family relationships.
- May never identify the child's misperceptions.

Traditional family therapy:

- Views the child's behavioral problems as a manifestation of the overall family dysfunction.
- Does not take into account the concept of imported pathology (the child bringing pathology into the family).
- May view the parent more as part of the problem than part of the solution.

Adoptive families, who represent the source of real change and remediation, must be actively involved in healing strategies.

Principles of a Family Systems Approach to Treatment in Adoption

- Although the adoptive family is not the source of the child's problems, it is within the context of family relationships that primary healing occurs.
- The interface between the characteristics of the child and family leads either to healing or adoption disruption (Barth & Berry, 1987).
- Many children are internally driven to reenact their earlier life experiences in the new family setting.
- The reenactment may lead to the adoptive parents looking quite dysfunctional by the time they seek help.
- It is more important that non-helpful patterns of family interactions be interrupted and new interactional behaviors be learned than that either parent or child be seen as the "cause" of the problem.
- Therapists need to empower the adoptive parents by including them in therapeutic interventions.
- When under stress and feeling vulnerable, individuals (parents and children alike) become more defensive, resistant, and rigid.
- Although neither the adoptive parent nor the therapist can undo the early damage from inadequate nurturing or abuse, they can minimize the scarring and help the adopted individual compensate by learning new skills.
- Any intervention that threatens the parent-child relationship undermines the goal of preserving the family as a resource for the child (Morton, 1991).
- Although we might prefer the "best interests of the child" standard, in reality we must frequently invoke "the least detrimental alternative available" standard.
- Decisions must be made considering not only the identified child's needs, but also the interests of the family as a whole, as these decisions will impact parents, siblings, and extended family members as well.

When Is Out-Of-Home Placement Necessary?

Out-of-home placement may be indicated in a wide variety of circumstances, ranging from brief respite to lengthy residential treatment, and from assessment to treatment. Special-needs adopted children have many reasons for possibly needing the most intensive therapeutic interventions.

Out-of-home placement should not be considered an adoption failure. Indeed, it may be a strong indicator of an adoption success when the family recognizes that their young person needs more help than they alone can provide, and they are willing and able to advocate that their child receive this help.

Children who are not experiencing success in any of the major arenas of their life-family, school, and peer relationships—are frequently candidates for out-of-home placement. Family and professionals should also assess the child's functioning within the community and his/her more personal

functioning. Looking at these areas in detail frequently helps determine the most beneficial type of placement. (Fahlberg, et al., 1989. Residential Treatment.)

Grotevant and McRoy (1990), in their research on children in residential treatment, found that although adopted and non-adopted youth had similar behaviors and diagnoses, there were significant differences as well. When compared with the control population, the parents of adopted youth had less mental health pathology and more stable marriages. Of the 50 adopted individuals studied, in 33 cases the adoption played a major role in their emotional disturbance; in nine cases it played a minor role, and in eight cases it seemed to play no role.

The intensity of family life at the period when the young person is reintegrating earlier life experiences and redoing the tasks associated with individuation and identity formation may interfere with successful achievement of the tasks at hand. Some youth are able to make much better use of their family when they are not living with them. The family may be able to be more emotionally supportive, because they are less drained, in this situation as well.

In summary, the goal of all post-placement services is to aid in maintaining the long-term commitment and accessibility of the family as a positive influence in the adopted individual's life.

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Abuse Issues in Special-Needs Adoptions

8

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Introduction

This chapter presents a curriculum for a workshop on abuse issues and therapies in special-needs adoptions. The workshop is designed to train mental health professionals in these issues. The following curriculum, supplemented by references and other materials noted below, can be used by trainers in conducting similar workshops.

Objective

This workshop is designed to familiarize participants with 1) the lifelong issues in adoption; 2) the residual effects of child physical and sexual abuse and neglect; 3) the clinical presentation of a youngster who has suffered both traumatic separation and loss and child abuse; 4) ethnic and cultural issues relating to child abuse; 5) the potential effects on the adoptive family of the introduction of an abused child; 6) the supports that adoptive families of abused children need, and 7) the therapeutic issues in treating such children and families.

Materials Needed

Hand-outs (attached), overheads and an overhead projector, a VCR and monitor, play materials. (See notes to trainers in the curriculum for details).

Time and Format

This workshop is planned for a minimum of seven hours. The material should be presented using a variety of teaching methods, including lecture, small and large group discussion and brainstorming, video or audio presentations, and role play.

Lecture

I. Introduction of the Material

Introduce the presenter(s) and ask participants to introduce themselves either individually or by a show of hands (e.g., "How many are triad members?" "How many are adoptive parents of special-needs youngsters?" etc.). Participants should then be given a brief overview of the planned activities for the day.

II. Goals for the Day

With participants, list goals for the day. Review objectives as listed above.

III. The Seven Core Issues in Adoption

The issues are:

- Loss/separation
- Rejection
- Guilt and shame
- Grief
- Identity
- Intimacy
- Power, control, mastery

Note to Trainer: *Review handout on "Seven Core Issues in Adoption" with the goal of assisting participants to view adoption as a lifelong, intergenerational process that is always influencing the individual's and family's life-cycle development.*

The "Seven Core Issues" provides a framework for understanding and discussing both normative issues and atypical presentations in adoption. Clinical issues in adoption are often best addressed using the "Seven Core Issues" as a template.

IV. The Abused Child in Placement

Note to Trainer: *Review with participants research on the demographics of abuse.*

Many, if not most, special-needs adoptees are victims of some form of abuse and neglect. These difficulties are the children's "tickets" to removal from their birth families, and the behaviors that result from the residual effects of that abuse can place the child at peril for abuse in foster care and adoption. A history of child abuse also places the adoptive family at risk for stress, emotional difficulty, and even allegations of abuse. It has become increasingly clear in the past few years that previously unresolved abuse issues are frequently tied to subsequent problems in attachment and threaten adoptive placements. It is imperative that mental health professionals working in the arena of special-needs adoption familiarize themselves with these issues and with appropriate interventions.

There is a great disparity in the research regarding the characteristics of children who are abused and those of the abusers. For example, individuals who neglect children represent a distinct group from those who sexually abuse children. Yet far too often children placed for adoption are described generally as "abused" without specification regarding the age at which the abuse occurred, the type of abuse, the frequency, the duration, the severity, or the identity of the perpetrator. These are all vital variables in looking at both the effects of the abuse and the appropriate clinical interventions.

Note to the Trainer: *Review with participants the materials on the short- and long-term effects of abuse on children, emphasizing the effect on all spheres of development. Using the works of Finkelhor (1993), Herman (1992), Peterson (1991), and Janoff-Bulman (1992), and audience large-group brainstorming, assist participants to develop an understanding of the psychological impact of trauma on children.*

The use of a video or audio tape of youngsters discussing their own abuse may help clinicians to both deepen their understanding of this issue and provide a common case for discussion and illustration of the materials being presented.

V. Abuse and Adoption: Increased Effects

The presence of both a history of abuse and a history of traumatic separation and loss increases the effects of each factor.

Note to Trainer: *This section brings together the materials covered to this point, assisting clinicians to understand the effects of abuse and separation when combined are greater than the sum of the two. Please use the handout to review this material with participants and to lead a discussion with the large group about the implications of these observations for families, children, and mental health professionals.*

VI. Ethnic and Cultural Concerns

Note to Trainer: *The materials to be presented in this component are highly sensitive and require ample time for discussion. Using four blank overhead transparencies, head each with the name of a different non-dominant culture, e.g., "Native Americans," "African Americans," "Asian Americans," and "Latinos." In a large group format, ask participants to brainstorm racial, ethnic, and cultural stereotypes about each group that impact children, families, and society. Participants may need assistance in distancing from the topic to give them freedom to say things that are personally offensive. Upon completion of the lists, engage the group in a discussion of the impact of these stereotypes on children, birth families, adoptive families, social workers, and clinicians. Discuss in light of same-race adoption and transracial and transcultural adoption.*

Although the sexual abuse of children and adolescents has been extensively reviewed in the literature, little attention has been paid to the role of ethnicity or race. Some small studies have examined childhood sexual abuse among African Americans and/or Latinos, comparing them to Caucasians. Interviews with community-based populations and retrospective chart reviews of sexually abused children indicate differences in characteris-

tics across ethnic and racial groups. For example, a 1982 study found that African-American female victims were evaluated for sexual abuse at a younger age than Caucasian or Latino female victims and African American victims and their families were less likely to be referred for treatment. (Finkelhor, 1993; Rao, et al, 1992; Horejsi, et al, 1992)

It is important to note when assessing children and families that child-rearing practices are culturally influenced, and that familial attitudes toward sexually abused children may vary across racial and/or ethnic lines. In addition, the child's response to having been sexually abused and then having to deal with reactions from the social support system may also be swayed by ethnic factors.

Children's and families' responses to abuse also differ among and between groups. Sexual acting-out was reported least among Asian victims, possibly reflecting cultural pressures against reporting it due to a cultural bias against discussing sexual matters outside the family. Asians are more likely to express suicidal impulses and are reported to be least likely to express anger and hostility. Further, Asian families are viewed as least likely to believe victims' disclosures about abuse.

Abused Latino children are viewed in the literature to be similar to Asian children in many ways; they are described as older than African-American or Caucasian children, and most likely to be living with the assailant. Latino families are reported as less supportive of the victim than African-American or Caucasian families.

African-American victims are demographically distinct; they are the youngest, least likely to come from intact families, least likely to be victims of interracial assault, and have suffered more physically invasive forms of sexual abuse.

Growth and developmental traumas associated with repeated disruptions in care may be compounded for the African-American child as a result of both historical and institutional racism. Avenues to healing for children already damaged by abuse and neglect may be blocked by these factors as well.

It is important to remember that most research into the effects of childhood abuse speaks to generalities; "Asians," for example, represent many diverse Asian cultures, languages, and degrees of accommodation. The same is true for Latinos. Race is not predictive of abuse; poverty is seen as the single most significant predictive factor. (Jones, 1992)

Most transracial and transcultural adoptions today involve children from outside the United States, including Asia, Central and South America, and now Eastern Europe, including Russia. Mental health practitioners need a working knowledge of these cultures to intervene effectively.

Another current concern about intercountry transracial adoption is the belief held by some adoptive parents that, by adopting abroad, they can avoid dealing with birth families and also avoid adopting abused children. Both ideas are based on faulty assumptions. Parents who have adopted transracially and transculturally may try to help children adjust by minimizing all racial and cultural differences. Discounting the role of race and ethnicity in the development of identity and self-esteem, some families make little effort to become involved in organizations, churches, neighborhood associations, or adoption support groups, which would expose children to others of their racial or ethnic background. Some parents may even refuse to allow the child to discuss their heritage or their history of abuse. Whether parents do this because they think it best for the children or because they themselves are uncomfortable with differences, the denial of the child's background can leave a child feeling isolated and confused. The youngsters know that they are not Caucasian, but, simultaneously, they are not allowed to feel truly Asian, Latino, or African American. They frequently lack a secure sense of belonging to a group with whom they can identify. When the birth family was abusive, children's negative feelings may be allowed to translate to the entire culture or race, further isolating the child.

Note to Trainer: *Allow time for discussion of this material and how these issues might play out in a clinical setting. Case examples would be very helpful.*

VII. Abusive or Neglectful Birth Parents

Note to Trainer: *Participants may have many questions or concerns about abused children's ongoing contact with an abusive birth family. The goal of this*

component is to elicit that information, explore the myths and realities of those concerns, and assist clinicians to work with individual children and families who may be involved in varying degrees of contact and openness with birth families.

Frequently in adoption, society creates an absolute dichotomy of birth families as all "bad" and adoptive families as all "good," thereby creating the potential for loyalty conflicts for the adoptee. When the additional factor of childhood abuse is introduced, adopted youngsters, bonded with the abusive birth parents *by the shared mutual experience of the trauma*, may have great difficulty in attaching to the new family if renunciation of the birth family is required either overtly or indirectly. Carnes (1993), in his work on sexual addiction and trauma bonds, explains why humans bond with those who hurt them. Trauma bonds, according to Carnes, are an overlooked expression of post-traumatic stress. Carnes postulates that trauma bonds are stronger:

- When the trauma cycles are repeated so that intensity and forgiveness become reinforcing;
- When the victim believes in their uniqueness;
- When the victim mistakes intensity for intimacy;
- When the trauma endures over time;
- When there are increasing amounts of fear;
- When the new chemical reactions created by the trauma occur earlier in life when the brain is more malleable;
- When the trauma is preceded by earlier victimization;
- When the victim is surrounded by reactivity and extreme responses;
- When the betrayal of power relationships is greater;
- When the betrayal of trusted relationships is greater.

Note to Trainer: *Discuss these factors with participants using a vignette of an abused adopted child, with the goal of aiding clinicians in understanding how adoptees remain bonded to their birth families, often in negative yet enduring ways, and how such negative trauma bonds can be disrupted while simultaneously fostering positive bonds to the birth family and a strong healthy attachment to the adoptive family. Involve participants in a discussion regarding their own and society's concerns about contact and openness in the adoption of abused youngsters. Help clinicians to brainstorm proactive ways adoptive families can foster openness and ongoing contact with abusive birth families while also providing safety and security for the adoptee. Use case examples from your personal experience or practice.*

VIII. Adoptive Family Issues

Adoptive families face many of the same issues as non-adoptive families and many additional concerns and tasks. The development of the family life cycle is significantly influenced by the presence of adoption in the birth and adoptive family. The adoptee's understanding of adoption unfolds over time, and how these aspects are handled are crucial factors in the adoptee's emotional growth.

Family Life Cycle Development (as conceptualized by Rhodes, 1977):

- Intimacy versus idealization or disillusionment
- Replenishment versus turning inward
- Individuation of family members versus pseudomutual organization
- Companionship versus isolation
- Regrouping versus binding or expulsion
- Rediscovery versus despair
- Mutual aid versus uselessness

Note to Trainer: *Use handout for this model or another developmental conceptualization to discuss with participants how stages of development in the family life cycle might be affected by the presence of adoption and abuse issues.*

Brainstorm with clinicians the characteristics of adoptive families that they believe would be most likely to yield success in parenting abused youngsters. Discuss.

Adoptive families who choose to parent abused special-needs youngsters need education and training specific to these issues. This education and training are best offered in group settings where families can also develop ongoing support networks. If such programs are not available in the local community, clinicians can extend their services to include educational and group experiences. Families should also be encouraged to read materials on abuse and adoption and to attend workshops and conferences on the subject. It is important that families become comfortable in discussing abuse issues with each other in the most intimate detail.

Note to Trainer: *Borrowing and expanding the ideas of Duehn, ask participants to take a clean piece of paper and write down a "secret" that they have about their sexual experiences or their first sexual experience. While they are writing, hand out blank envelopes, asking them to place their paper in the envelope. The envelopes should be sealed and a personal identifying mark placed on the outside. Ask participants to give their envelope to someone in the room who is most different from them regarding sex, culture, race, etc. Explain that this is not an exchange, so that one person could receive many envelopes and others, none. Instruct that the envelopes are not to be opened. Debrief participants about their feelings while writing, their feelings while passing the envelopes, how they chose to whom to give the envelope, their feelings about holding someone else's "secret," what they think should be done with the envelopes, etc. Ask participants what they believe is the goal of this exercise. The goals are to enable clinicians to understand the way youngsters and families feel when they are asked to discuss intimate details of their lives; that these feelings vary if the recipient is of another sex, race, or ethnic group; that mental health professionals must "hold" these secrets with the utmost respect. Continue the discussion until the group seems comfortable. Be sure the envelopes are returned to their owners.*

It is also very important that the issues and concerns of siblings in the adoptive family be addressed. A review of the literature on family therapy with adoptive families reveals that many clinicians do not regularly include siblings in the work although siblings are greatly affected by the introduction of an abused child into the family. Siblings may take on a variety of roles vis-à-vis the adopted child, including rescuer, enabler, scapegoat, perpetrator, and caretaker. Families need assistance in engaging siblings in the process of incorporating a new child and in monitoring and possibly remediating the impact of the adoption.

IX. Working with Families Who Have Abuse Issues in Their Families of Origin

Given the high reported numbers of both men and women who are abused as children, a logical inference is that many prospective adoptive parents will either have been abused themselves or will have experienced the abuse of someone in their family of origin. Conventional social work wisdom has been to exclude these individuals from adopting in the belief that their personal issues hold the potential to confound the issues of the abused adoptee. Current thinking is to recognize that the presence of previously *unresolved* abuse issues may have significant negative impact on the adoptive placement. On the other hand, individuals with this element in their history can serve as fine adoptive parents as long as they can distinguish between their issues and the child's, seek professional consultation and assistance as needed, and are comfortable in discussing these issues with each other, the child, the social worker, and the mental health clinician. Wholesale rejection of this pool of applicants is a disservice to them and to waiting children.

X. Creating Appropriate Personal and Family Boundaries

Children who have been abused have experienced numerous violations of their boundaries and personal space. This manner of relating may be the only style with which they are familiar, and they may continue to behave in this fashion when placed into the adoptive family. Families, then, require assistance in setting and maintaining appropriate boundaries among members that provide a feeling of safety and comfort for all.

Note to Trainer: *The work of Dolan (1991) on developing a "safety scale" and an "object of safety" provides*

ways in which clinicians can assist families in achieving this goal. Participants may also wish to offer their own experiences in helping families to create boundaries and a sense of safety.

Duehn demonstrates via a role play how families must openly discuss sexual boundaries with the newly-placed child. Trainers could either show this video or participants could enact their own role play with assistance from the trainer.

Families need to develop rules, expectations, and an atmosphere of safety. Discipline in special-needs adoption of abused children varies greatly from that appropriate for non-adopted, non-abused youngsters. The issues of attachment, the seven core issues in adoption, and the potential for the child to misinterpret and provoke parents' actions must all be factored in when designing discipline strategies.

Abused youngsters frequently seek to act out previous abuse either through externalized or internalized behaviors. Among the most problematic of the externalized behaviors are those of youngsters who molest other children. There may be a large number of molested children in this country who turn around at startlingly young ages and become child molesters themselves. This is a long-unrecognized problem, primarily because social workers, clinicians, and parents prefer to see children as victims rather than as potential perpetrators of abuse. Most people choose to ignore the signs of these behaviors in children and adolescents.

Note to Trainer: *Refer participants to MacFarlane and Cunningham (1990).*

Another 90 percent of youngsters participating in a model treatment program in the Los Angeles area (the "SPARK" Program) were themselves molested. The majority are boys, but the program directors report that they are beginning to see more girls. The dominant themes for these youngsters are a desire to gain a sense of power and control and an identification with the aggressor. Parents need education about normal childhood sexual development, and they need to pay attention to behaviors that contain more than average sexual curiosity, including obsessive masturbation and more than a two-year age difference between children involved in sex play. Adoptive parents often refuse to believe what they are seeing. Studies show that 58 percent of adult sexual offenders report having begun sexually acting-out as juveniles or adolescents.

Adolescents are a particularly vulnerable population. The exact incidence of sex crimes committed by adolescents is not known. The assessment and treatment of adolescent sex offenders are broad, complex clinical areas that presently lack empirically verified evaluation or therapy techniques. Mental health professionals often underestimate the significant risks involved with adolescent sex offenders.

XI. Responding to Allegations of Abuse in the Adoptive Family

There are a variety of circumstances that can lead to allegations of current abuse in the adoptive family. Such allegations are always disturbing and difficult to discuss. Clearly, prevention is the first goal, and suggestions for education, training, establishment of appropriate boundaries, and discipline are all primary prevention interventions. Nevertheless, allegations do arise. One class of such allegations is those that are ultimately substantiated. Factors in the structure of the adoptive family may create an atmosphere where abuse can occur, including unresolved loss and grief, barriers to intimacy and trust, a diminished sense of control, and provocative, attention-seeking, and other negative behaviors of the child.

Note to Trainer: *Review with the audience the Seven Core Issues in Adoption (III above) and the Increased Effects of Abuse and Adoption (V above). Ask clinicians to discuss how these may create an abuse scenario in the adoptive family.*

The risk may increase as children unconsciously attempt to re-create scenarios from their dysfunctional birth families. Children may be exceptionally provocative and even physically abusive themselves, or they may be sexually inappropriate ei-

ther with parents or siblings. Families who simply wanted to give a child a good home and love may be caught off guard and be unable to control their own impulses, with tragic results.

A variety of factors may also cause false allegations of abuse in the adoptive family. Youngsters who have been involved in the system or who have deficits in the development of a conscience may consciously or unconsciously make reports of abuse. Some children who were severely traumatized by physical and sexual abuse may experience flashbacks that are triggered by events in the adoptive family. They may be uncertain whether they are being abused now. Older children who fear getting close or who cannot tolerate receiving love may consciously make false reports to be removed from the adoptive family. Careful investigations of all these possibilities need to occur before any judgments or decisions are made. Families can protect themselves by being open and honest with professionals and also discussing the issues within the family. Parents can also write out their child's history and give it to friends for safekeeping in case allegations arise. (See *Adopted Child Newsletter*, September, 1984.)

XII. Therapy

It is vital that mental health professionals who are asked to intervene in adoptive families of abused children clearly define their role(s). Most adoptive families were healthy, well-functioning units before the placement of the special-needs youngster. Therapy, then, often takes on more of a consultation/education function than the treatment of psychopathology. Even the dysfunction of the newly-placed child is usually best addressed in the context of family therapy. There are inherent dangers in seeing the child for any prolonged period in individual therapy, including the child's becoming attached to the therapist instead of the family, the parents feeling that the therapist believes that they are not adequate to address the child's needs, inadvertent collusion, scapegoating and blaming, divided loyalties, and dysfunctional communication.

The "successful" therapist/counselor:

- Is well-versed (through specialized training and experience) in working with adopted youngsters and their families; recognizes that adoptive families are different (not better or worse) from traditional nuclear families; has knowledge of attachment issues and techniques;
- Believes that adoption is a healthy, positive way to build families; can see over the long term, not just the immediate "crisis"; sees the adoptive family as a family for a lifetime;
- Likes children and adolescents;
- Can differentiate among normal developmental issues, normal adoption adjustment, and abnormal events;
- Is familiar with grief work in children and adults;
- Is able to use many modalities (forms) of therapy; is active and flexible;
- Is aware of and uses community resources and supports, e.g., adoptive parent groups;
- Works with adoptive parents and adoptions staff as a team;
- Can avoid rescue fantasies;
- Can be open, honest, and genuine;
- Can see family's and child's strengths, as well as areas needing work;
- Has dealt with own anger toward birth parents; and can accept and work with children's attachment to birth families and previous caretakers.

When a team of social workers, parents, educators, medical personnel, etc. decides to add a mental health professional, that person must be willing to join the team and work collaboratively. Additionally, although special-needs adoptive families may often look "crazy" as they struggle to come together and incorporate a child from another family with a variety of experiences, special-needs adoptive families are for the most part sane, although distinctive. Professionals need to avoid labeling either the family or the child as pathological, working instead to create solution-oriented, collaborative interventions.

The current solution-focused therapies (see Dolan, 1991; O'Hanlon, 1989; and deShazer 1985, 1988) hold much promise for adoption work. Based on a belief that individuals and families hold within themselves the solutions to their problems, these

therapies seek to "co-create" resolutions with therapists and clients working as collaborators. The work is for the most part time-limited, positive, and empowering. Many solution-focused therapists incorporate the hypnotic/metaphorical work of the late Milton Erikson (1976, 1979).

Any assessment of an adoptive family seeking mental health services must be directly tied to a treatment plan. The fundamental goals of the therapeutic intervention are to provide corrective and reparative experiences for the child and to assist the adoptive parents in learning how to become a "healing resource" for the child. Therapy can also provide opportunities for corrective emotional experiences. Therapists can help families provide the child with opportunities to feel safe, and learn about appropriate interactions that lead to feelings of greater safety, trust, and well-being; in other words, teaching the child about the potentially rewarding nature of human interaction.

Reparative experiences both in and outside therapy allow the child to process traumatic events in ways they can be consciously understood and tolerated. When designing a treatment plan, mental health professionals must not consider presenting symptoms in isolation, but rather maintain a multi-systems perspective that includes birth and adoptive families, school, peers, community, religious, and medical systems. The primary goal of the treatment is establishment of a home setting where the child feels safe and family interactions are corrective in nature, providing opportunities for self-exploration, adaptation, and the development of new (functional) behaviors. It is important that clinicians intertwine abuse and adoption issues, being mindful of the influence and interplay of each.

The therapeutic work must also assist the adoptee to achieve developmental tasks appropriate for his/her stage of development. Pre-adolescent issues may include inappropriate sexualization, aggression, and antisocial behaviors. Adolescent issues often reflect questions of low self-esteem, self-image, stigmatization, role confusion, and peer relations.

It is beneficial to develop home assignments that increase positive interactions among family members. Therapists must respect the child's need to proceed slowly with issues related to closeness and intimacy, especially with physical touch, but not allow the child to remain "stuck" and avoid attachment. Watch for pseudo-attachments and for reenactment of family-of-origin dynamics. When they occur, correct them immediately in session. It is also useful in session to encourage posttraumatic play, which affords opportunities for pattern interruption, interpretation, and corrective experiences. Whatever the activity in session, the therapist must be active and require the family to be active as well. Therapy will be "unfolding" and dynamic. Set concrete behavioral objectives; involve the parents and child. Allow for measurable progress and development of a sense of mastery. Monitor the child for signs of dissociation, and teach both child and parents to do so. Teach grounding techniques for use in session and at home. Include both prevention and education to repair knowledge deficits. Teach and model skill-building.

Many specific techniques are helpful in working with abused children, including clinical hypnosis, drawings, mutual story-telling, metaphors, and projective story-telling. Sand tray therapy, posttraumatic play as developed by Gil (1994), and writing techniques are all frequently productive. Adopted youngsters need to have a lifebook. If the adoptee does not have one, an important activity of the therapy can be to develop one. Timelines of the child's life and placement history are helpful for the child, family, and therapist to better understand the child's life experiences prior to the adoptive placement. Most of these techniques, although originally developed for individual child-centered play therapy, can be easily and rewardingly adapted to family therapy work. At times, the parents may serve as witnesses to the child's work; at other times, the parents may be actively involved.

There are several family therapy techniques that are also productive in working with adoptive families. Most involve play as well. Gil (1994) states that the integration of play with family therapy strengthens both therapeutic approaches. Family therapy with adoptive families focuses on the interplay between family members who are working together to form a whole or a system. It serves to facilitate that process. The use of play in a family assessment, then, gives a firsthand view of how the family is organized; of verbal and nonverbal communication skills and patterns; of how family mem-

bers negotiate issues of fairness, limit setting, and conflict; and of how the attachment is coming together and other interactional dimensions in the family. Play for the most part reduces defenses and elicits deeper levels of interaction in which fantasy, metaphor, and symbol emerge. Play brings people together in a common pleasurable task. Useful techniques include puppets, art, mutual storytelling, feeling cards, psychodrama, and sand tray (Gil, 1994).

XIII. Rituals and Ceremonies

Finally, the inclusion of rituals and ceremonies both as part of family therapy and in the home environment helps concretize important aspects of the family's development, facilitate healing transitions, and create connections. Rituals draw attention and provide an avenue to facilitate the process. Ceremonies create both a focus and a container. Most often these rites have witnesses and participants who lend their support. Symbols are important in a ritual ceremony. Symbols are concrete objects connected with ("linked symbols") or representing ("created symbols") some situation, experience, or person. They are used to externalize and concretize an internal experience. Usually there is a leader or celebrant. Often religious leaders are willing to officiate at adoption-related ceremonies. For additional ideas regarding the use of rituals see Imber-Black, et al, (1988).

Rituals fall into several categories:

- Regularly repeated rituals: Activities you can count on, daily, seasonally, or on holidays.
- Continuity/connecting rituals: Restoring previous rituals or prescribing a ritual that restores or makes connections to people or situations.
- Rituals of remembering: Helping connect people with memories, the past, and disconnected resources.
- Rites of passage: Designed to move people from one role or developmental phase to another and to have that transition validated and recognized by others in their social context.
- Rites of inclusion: Designed to make people part of a social group or relationship.
- Rites of mourning/leaving behind: Designed to facilitate or make concrete the end of some relationship or connection.

Phases of the ritual include: introduction/co-creation; preparation; performance; cleansing/respite; and integration/celebration (O'Hanlon 1993). Examples of rituals include the symbolic inclusion of an absent birth family into the adoptive family circle, claiming the newly adopted child into the adoptive family, mourning ceremonies for the child's lost past, and healing activities to reclaim and nurture the body.

XIV. Role Play

Note to Trainer: *Prepare a case or several cases for role play. Ask for volunteers to play out the case in front of the large group and then break into small groups for discussion. It is recommended that the case involve as many of the issues covered in this presentation as possible. Offer play materials to simulate play techniques in family therapy. Small groups might focus on dominant themes of the case (organized around the core issues in adoption); strengths, skills, and resources of the adoptive family; and the treatment plan. These materials can then be discussed in the large group.*

XV. Questions and Answers

Note to Trainer: *Allow for ample time to address any questions that remain. Encourage participants to make a commitment (either publicly or privately) to utilize at least one item from the material presented immediately on return to their practices.*

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HANDOUT #8-1 Seven Core Issues in Adoption

	Adoptee	Birth Parent	Adoptive Parent
Loss	Fear ultimate abandonment; loss of biological, genetic, cultural history. Issues of holding on & letting go.	Ruminate about lost child. Initial loss merges with other life events; leads to social isolation; changes in body & self image; relationship losses.	Infertility equated with loss of self & immortality. Issues of entitlement lead to fear of loss of child & overprotection.
Rejection	Personalize placement for adoption as rejection; issues of self-esteem; can only be "chosen" if first rejected. Anticipate rejection; misperceive situations.	Reject selves as irresponsible, unworthy because permit adoption; turn these feelings against self as deserving rejection; come to expect & cause rejection.	Ostracized because of procreation difficulties; scapegoat partner; expect rejection; may expel adoptee to avoid anticipated rejection.
Guilt/ Shame	Deserving misfortune; shame of being different; may take defensive stance/ anger.	Party to guilty secret; shame/guilt for placing child; judged by others; double bind; not OK to keep child & not OK to place.	Shame of infertility; may believe childlessness is curse or punishment; religious crisis.
Grief	Grief may be overlooked in childhood, blocked by adult, leading to depression/acting out; may grieve lack of "fit" in adoptive family.	Grief acceptable only short period but may be delayed 10–15 years; lack ritual for mourning; sense of shame blocks grief work.	Must grieve loss of "fantasy" child; unresolved grief may block attachment to adoptee; may experience adoptee's grief as rejection.
Identity	Deficits in information may impede integration of identity; may see search for identity in early pregnancies, extreme behaviors in order to create sense of belonging.	Child as a part of identity goes on without knowledge; diminished sense of self & self-worth; may interfere with future parental desires.	Experience diminished sense of continuity of self; are & are not parents (Kirk's "Role Handicap").
Intimacy	Fear getting too close & risk reenacting earlier losses; concerns over possible incest; bonding issues may lower capacity for intimacy.	Difficulty in resolving issues with other birth parent may interfere with future relationships; intimacy may equate with loss.	Unresolved grief over losses may lead to intimacy/marital problems; may avoid closeness with adoptee to avoid loss.
Control	Adoption alters life course; not party to initial decisions; haphazard nature of adoption removes cause & effect continuum.	Relinquishment seen as out of control disjunctive event, interrupts drive for self-actualization.	Adoption experiences lead to "learned helplessness" sense mastery linked to procreation; lack generativity.

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HANDOUT #8-2 The Impact of Child Abuse

Short-Term Effects — Occurring Within Two Years of Abuse

(Finkelhor, 1986)

- Fear or anxiety
- Depression
- Difficulties in school
- Anger or hostility
- Inappropriate sexualized behavior
- Running away or delinquency

Physical Abuse

(Martin, 1976; Martin & Rodeheffer, 1980)

- Impaired capacity to enjoy life
- Psychiatric symptoms, enuresis, tantrums, hyperactivity, bizarre behavior
- Low self-esteem
- Learning problems in school; deficits in gross motor development, speech, & language
- Withdrawal; impaired social skills with peers
- Opposition
- Hypervigilance; mobilization of defenses in anticipation of danger
- Compulsivity
- Pseudomature behavior; role reversal with parents
- Interpersonal ambivalence
- "Chameleon nature" — shifting behavior to accommodate others
- Learned helplessness
- Lack object permanence or object constancy

Neglect

(Polansky, 1981)

- Deprivation — detachment
- Massive repression of feelings (affect inhibition)
- Impaired ability to empathize with others
- Violence
- Delinquency
- Decrease in intellectual ability (due to lack of cognitive stimulation on the part of the parent)

Emotional Abuse

(Garbarino, 1987)

- Behavioral problems (anxiety, aggression, hostility)
- Emotional disturbance (feelings of being unloved, unwanted, unworthy)
- Inappropriate social disturbance (negative view of the world)
- In infants, irritability and, in some cases, nonorganic failure-to-thrive
- Anxious attachment to parents
- Fear or distrust
- Low self-esteem
- Feelings of inferiority; withdrawal; lack of communication
- Self-destructive behavior (self-mutilation, depression, suicidal tendencies)
- Tendency to act as caretaker to parents
- Delinquency or truancy

HANDOUT #8-3 Long-Term Effects of Trauma

- Repeated trauma in childhood forms and deforms personality due to adaptation
- Abnormal states of consciousness which permit elaboration of array of symptoms, both somatic and psychological; fragmentation as central principle of personality organization
- Overwhelming sense of helplessness; high need for control and predictable environment
- Hypervigilance, scanning of environment; disruption of bodily self-regulation and regulation of emotional states
- Hiding, avoiding, fearing anger/confrontation
- Co-dependency; impaired sense of autonomy; abandonment fears
- "Doublethink": not see what see, not know what know, etc.; impairments in cognition and memory
- Impairments in identity and in capacity to form stable relationships; development of "double self" (Herman, 1992); self-blame, sense inner badness, stigmatized identity
- Disturbances in self-regulation — eating, sleeping, sexuality

HANDOUT #8-4 Abuse & Adoption: Increased Effects

Clinical Issues

Abuse	*Adoption*
fear/anxiety	anxiety, especially around separation
depression	depression, related to loss
difficulties in school	school/learning problems
anger	anger — grief reaction
inappropriate sexual behavior	
shame/low self-esteem	low self-esteem; impaired identity
hypervigilance	alert to threats of separation
flashbacks	preoccupation with loss
psychic numbing	"stuck" in grief process
feelings of detachment from others	attachment/intimacy difficulties
difficulties with body integrity/"damaged goods"	poor boundaries; sense not having been born
restriction of affect	depressed affect
hyperarousal: sleep difficulties, irritability, exaggerated startle response	difficulty sleeping — because of separation
confusion, esp. family roles & responsibilities	confusion re: loyalties
victimization: identity as victim/powerlessness	victimization: lack control over what happens
dependence vs. independence conflicts	dependency issues; fear rejection

HANDOUT #8-5 Sexualized Behavior

Finkelhor's Traumagenic Dynamics: Four Factors

- Sexualization
- Stigmatization
- Powerlessness
- Betrayal

Finkelhor & Browne (1986) define traumatic sexualization: "A process in which a child's sexuality (including both sexual feelings and sexual attitudes) is shaped in a developmentally inappropriate and interpersonally dysfunctional fashion as the result of sexual abuse."

Dynamics

(Finkelhor, 1986)

- Child rewarded for sexual behavior inappropriate to developmental level
- Offender exchanges attention & affection for sexual behaviors
- Sexual parts of child fetishized
- Offender transmits misconceptions about sexual behavior & morality
- Conditioning of sexual activity with negative memories & emotions

Psychological Impact

- Increased salience of sexual issues
- Confusion about sexual identity & sexual norms
- Confusion of sex with love & care getting or care giving activities
- Negative associations to sexual activities & arousal sensations
- Aversion to sex or intimacy

Behavioral Manifestations

- Sexual preoccupations & compulsive sexual behaviors
- Precocious sexual activity
- Aggressive sexual behaviors
- Promiscuity

HANDOUT #8-6 **Externalized/Internalized Behaviors** (Gil. 1988)

Externalized Behavior

- Direct behavior toward others; outward expression of their emotions
- Aggressive, hostile, destructive, violent, sometimes torturing animals
- Provocative (eliciting abuse)
- Fire-setting
- Overtly sexualized behaviors

Internalized Behavior

- Isolated/withdrawn; appear unmotivated to seek interactions
- Exhibit clinical signs of depression
- Lack spontaneity & playfulness
- Are overcompliant
- Develop phobias with unspecified precipitants
- Appear hypervigilant and anxious
- Experience sleep disorders or night terrors
- Demonstrate regressed behavior
- Have somatic complaints (headaches, stomachaches)
- Develop eating disorders
- Engage in substance and drug abuse
- Make suicide gestures
- Engage in self-mutilation (grounding, comforting, ascertain own humanity)
- Dissociate

HANDOUT #8-7 Specific Techniques to Recognize Dissociation in Children

Progress from general, non-specific to more directive

1. Ask child to draw themselves on the inside "the places we can't see with our eyes"; do same for family.
2. Ego state evaluation (Watkins, 1981)
3. Use Peterson (1991) or other dissociation checklists.
4. Use imagery to "go on a trip to find 'someone' who can explain to us what has happened to you/her/the body".
5. Use "dissociative play" creating distance and an observer.
6. Ask about hearing voices on the inside or the outside.
7. Use dissociative language: "I wonder if there's a part of you which could tell me about what happened," etc.
8. Explain dissociation to child and ask if ever happened to him or her.
9. Ask for information from the back or inner mind; develop metaphors and stories to explore this, using child's imaginative world, i.e., super heroes, Star Trek, etc.
10. Watch for sudden changes in behavior, affect, voice, language; ask parents about these unexplained changes in the home.
11. Ask child "Where does the forgotten stuff go?" Develop trip to go to that place.
12. Utilize imaginary companions whose job it is to … brush teeth, go with Mom and Dad (non-emotional to emotionally reactive).
13. Ask child to concentrate very hard, ask to speak to person(s), part(s) of you who did _____. "Is there any part of anybody who knows about _____?"
14. Read books about dissociation or write own book about child who has parts.
15. All of above need to be done over time and may need to be repeated as trust in therapeutic relationship develops.

HANDOUT #8-8 The Life Cycle of the Family: Normal Development

Adapted from Rhodes (1977, May).

I. Intimacy vs. idealization or disillusionment

- Couple invests in relationship
- Achievement of intimacy based on reality
- Each partner assumes responsibility for oneself in relationship
- Courtship patterns and expectations, nature of early interactional pacts, vying for power positions, assignment of roles and responsibilities are early indicators of couple's mutual capacity for intimacy
- Goal: true intimacy is to achieve workable complementarity

II. Replenishment vs. turning inward

- Childbearing years; begins with first child; ends when last child enters school
- Task: Development of nurturing patterns among all family members
- Important family members, especially parents, able to replenish themselves; need identify "refueling" resources
- Dyad becomes triad
- Can dyad survive? Does mother / child bond exclude father or symbiotic marriage exclude child?

III. Individuation of family members vs. pseudomutual organization

- Passed through bearing and rearing of preschool child
- Family shift the foci of energies from family to individual interests
- Parents must prepare for an identity not defined by one's roles and responsibilities within the family (crisis especially for women who define themselves as caretakers)
- Children's increasing self-sufficiency propels them into world
- Danger if family denies support and limits opportunities for development outside the family
- Examine parental messages about nonfamily world
- Concept (Wynne) of pseudomutual family: Preserves harmony and denies differences; closeness equals fusion; acceptance comes from accommodation to family "dogma"; only security found in belonging; suffocating attachments
- Ability of family to support and nurture individuation single most important feature of healthy family

IV. Companionship vs. isolation

- Teenage children
- Teen's burgeoning sexuality and separation themes dominant
- Task: Develop companionship outside the family
- Teens move into peer groups
- Couple renews marital relationship
- Shift in parent / child relationship away from authoritarian stance; allow children more decision-making powers; more discussion
- If tasks not completed, leads to isolation; parents may invade children's lives and impede disengagement

V. Regrouping vs. binding or expulsion

- Children leaving home to establish lives separate from parents
- Crisis in coping with advancing independence of offspring and bio-psycho-social pressure for separation
- Task: Allow departure of children as natural outgrowth
- Accomplishment of task rests on viability of marital relationship and on resources within sibling and peer relationships to support separation efforts
- Regroup along generational lines
- Danger of binding or premature expulsion

VI. Rediscovery vs. despair

- Post-parental phase
- High percentage of divorces in this stage
- Durability of marriage depends on adaptations sought to reestablish satisfactory marital balance
- Period of rediscovery of marriage partner; roles divested of parenting roles
- Renegotiate role with children: Now adult to adult

VII. Mutual aid vs. uselessness

- Post-parental stage
- Period from retirement to death
- Grandparents
- Intermeshing of life tasks for several (usually three) generations
- Task: Develop mutual aid system which combats generational disconnectedness and feelings of uselessness
- Includes negotiating spheres of competency, acceptance of real and psychological needs, and willingness to give and get

HANDOUT #8-9 Openness in Adoption of Abused Children

Adapted from Melina, L, & Kaplan Roszia, S (1993).

Many myths prevail:

- Children should *never* have contact
- Best for child to forget about birth family
- Child can't love "those people"; don't want contact with people who have hurt them
- Abusive birth parents don't deserve contact with their children
- Abusive birth parents will hurt children again
- Adoptive parents who are parenting these children shouldn't have to / will not deal with the birth parents

Unfolding realities:

- Abused children are attached to their birth parents
- Abusive parents can offer their children things adoptive families cannot, including permission to attach to new family and reliable, balanced information
- Children and adults do better dealing with reality, even when harsh, than with secrets and fantasy
- Abuse issues frequently can be "resolved" more quickly and thoroughly when child confronts reality of birth parent(s); children can "heal" traumas and forgive birth parents, thereby acquiring a sense of freedom from past and permission to become "themselves"; contact helps circumvent divided loyalty issues and kidnap fantasies
- People change and grow; abusive birth parents may be more available for a relationship with child a few years down the road
- For some, openness allows child to be adopted; birth parents who meet adoptive parents may relinquish child voluntarily, circumventing long legal process filled with animosity and appeals
- Birth parents who had problems with substances can provide education better than "preachy" adoptive parents
- May give adoptive parents access to important information about their child's birth history

Birth and adoptive families may need help to discuss these issues and develop a plan or contract which, while attempting to meet everyone's needs, focuses on the needs of the adoptee *over time*.

HANDOUT #8-10 Characteristics of Families Successfully Parenting Abused Youngsters

- Evidence of ability to take risks, especially related to children; good history having resolved problems/crises; no need for crises
- Well-established, open and direct communication in the marriage
- Perseverance or an ability to wait for child's commitment while making one's own without reservations
- Operative support systems
- Intact sense of self-satisfaction that does not need to be shored up by child; does not "need" this child
- Sense of humor and proportion; creativity
- Experience in having parented child same age as incoming child
- Intuitive perception or nonverbal communication
- Spontaneity of expression; ability to handle intense affect
- Structure, ability to set boundaries, yet ability to be flexible and open
- Lack judgmental attitude toward birth family; willingness to include child's past into family; willingness to learn about child's past, including willingness to confront directly the abuse done to the child
- Lack of investment in middle-class propriety
- "Busy"/active family; balance among activities — family, individual, other groups
- Find differences "interesting"; open to doing things a variety of ways

HANDOUT #8-11 The Treatment Plan

Fundamental Goal

- Provide *corrective* and *reparative* experiences for child; assist adoptive parents in learning how to become "healing resource" for child.

Corrective Experiences

- Provide child with opportunities to feel safe, and learn appropriate interactions that lead to feelings of safety, trust, and well-being; i.e., teach child potentially rewarding nature of human interaction.

Reparative Experiences

- Allow child to process traumatic events in ways they can be consciously understood and tolerated.
- When designing treatment plan, do not consider presenting symptoms in isolation; maintain multi-systems perspective: birth and adoptive families, school, peers, community, medical
- First Goal: Establish home setting where child feels safe and family interactions are corrective in nature; provide opportunities for self-exploration, adaptation, and development of new (functional) behaviors
- Need to intertwine abuse and adoption issues, being mindful of both at all times
- Work toward assisting adoptee to achieve the developmental tasks appropriate for his/her stage of development
  - Pre-adolescent issues: Inappropriate sexualization, aggression, and anti-social behaviors
  - Adolescent issues: Low self-esteem, self-image, stigmatization, role confusion, and peer relations
- Develop home assignments which increase positive interactions among family members; respect child's need to go slow with closeness, especially physical, but do not allow child to remain "stuck" and avoidant; watch for pseudo-attachments
- Watch for reenactments of family of origin dynamics; correct in session
- In session, encourage posttraumatic play (use variety of techniques to elicit material); therapist must be active and require family to be active as well
- Therapy will be "unfolding"; dynamic; be creative and flexible in responding to changes; be sure you have good rationale for changes in plan
- Set concrete behavioral objectives, involve parents and child; allow for `measurable progress, sense of mastery
- Monitor for dissociation; teach child and parent to do so; teach grounding techniques
- Include prevention and education — repair knowledge deficits; teach/model skill building

The Attachment Disordered Adoptee

9

Barbara Rila, Ph.D.

Attachment issues are sufficiently prevalent in the adopted child that adoption therapists need a knowledge base about attachment theory, issues, and treatment. Attachment is defined as the reciprocal affectional bonds that develop between two people. Not all attachments are between parent and child, but the following material will focus on parent/child attachments.

Attachments are built with the arousal/relaxation cycle depicted by Fahlberg on the first handout at the end of this article. Infants experience need and express displeasure. In response, the adult caregiver satisfies the needs of the child, who is in turn able to reestablish a sense of satisfaction and quiescence. The many repetitions of this cycle establish the child's trust in the caretaker, give satisfaction to the caregiver, and form the foundation for the ongoing development of attachment.

Because children placed for adoption are separated from their birth parents, and therefore their birth culture, community, roots, or identity, they are placed at risk of developing attachment difficulties. Although there is a wide variation in infant response to this initial and early separation, children placed for adoption may experience some form of attachment difficulty. In addition to the parent/child separation, preadoption trauma such as abuse, sexual abuse, and parental abandonment will affect a child's ability to attach. The child's prenatal environment may be a factor as well. Maternal substance abuse, poor prenatal care, and head injuries during pregnancy, are thought to impact the child's later ability to attach, due to changes in brain functioning.

Difficulties that arise from poor parent/child attachment include: Ambivalence regarding parental figures, confusion in the development of identity, unresolved grief, failure to trust others, heightened anxiety, inability to accept love and nurturing, intellectual and cognitive problems, emotional problems, difficulties appropriately expressing affect, stress sensitivity and vulnerability, failure to develop empathy and a conscience, failure to develop coping skills, and developmental delays. These problems compound the attachment difficulties and often become the focus of treatment. If the underlying attachment issues are not also addressed, the therapy will inevitably fall short.

Attachment is by no means always a problem for adopted children. It is, however, an issue for children who have been traumatized in the context of the parent/child relationship, and it may be part of the background of the adoptive family's life together.

Attachment theory has been extensively reviewed in the article, "Becoming Attached", by Karen (1990), which has since been expanded to book form. This is an excellent review of the theory, literature, and research, as well as some of the practical applications, coming from attachment theory.

A recent volume, *Mother Infant Bonding; A Scientific Fiction* by Eyer (1992) captures the arguments against attachment theory. This volume criticizes the original studies and data that established the foundation for attachment theory. The author suggests that attachment theory overlooks the genetic contribution to temperament, which in turn impacts the parent/child relationship. The author's primary concern about attachment theory is that it reflects social values that seek to restrict women.

Despite these arguments, attachment theory is intuitively obvious. It is an observable series of events, and is clearly responsive to trauma, such as

separation of parent and child. Furthermore, attachment theory holds the prospect of assisting in the humanization of foster care and adoption, in which we strive to maintain birth family ties wherever possible, promote the establishment of affectional relationships in foster care settings, and move quickly to adoption, seeking permanence in children's attachment relationships.

Types of Attachment Difficulties

Four types of attachment difficulties in children are described in research by Ainsworth (*Patterns of Attachment*, 1978). Securely attached children, which comprise approximately 60 percent of the population sampled, will protest separation and rejoice upon reunion with their caregivers. Ambivalent children, approximately 10 percent of the population, will demonstrate clingy, demanding behaviors, but will reject soothing by their caregivers. Avoidant children, which are thought to comprise 20 to 25 percent of the population, will explore their environment, but will tend to avoid contact with their parents. A new category of children exhibits a disorganized attachment. These children seek their parents in unusual and contradictory ways, such as backing up into them, for contact. These children often have a history of abuse and neglect.

The Diagnostic and Statistical Manual, IV Edition contains the standard diagnostic criteria for a reactive attachment disorder. The predominant characteristics include a "persistent failure to initiate or respond to social interactions" or "indiscriminate sociability." This diagnosis assumes that caregiving ignores the child's needs, physically and emotionally.

The clinical setting most typically includes the insecure child, who clings to and shadows parents in a demanding and intrusive way; the ambivalent child, who has a strong love-hate relationship with parents and has interactions that easily lead to feelings of rejection, betrayal, and anger; and distorted attachments, often present in the child with a history of abuse. The distortions in the latter represent attachment styles and patterns developed in the dysfunctional families in which the child previously lived. Finally, there is the unattached child, who has received much media attention, but is in fact quite rare. This is the child without a conscience, who is inordinately friendly with strangers, but extraordinarily hostile within the family, and who has a series of bizarre and dangerous behaviors. Usually attachment difficulties will be represented not by a lack of attachment, but by an aberrant form of attachment.

Parents' attachment to their children is critical to the child's development. Without attachment to their child, parents are not motivated to protect, provide affection, and give basic care to the child. Evaluating the adult-to-child attachment is critical, because it helps assess the viability of the relationship, the parent's ability to refrain from abuse and provide discipline, love, and nurturing.

The work of Ainsworth also describes styles of parent-to-child attachment. The autonomous parent is the healthy model to which we aspire. The dismissive parent is the equivalent of the avoidant child. This parent is indifferent to the child. The preoccupied parent is analogous to the ambivalent child, and presents as a confused and angry parent. The disorganized parent often experiences unresolved childhood abuse and abandonment. A category could also be added, describing the traumatized adult, who has been so traumatized in the context of the parent/child relationship that he or she may show aberrations in parenting style and ability. Yet, other parents fit the category of unattached adults and are prone to abuse and neglect. In foster care and adoption, unattached parents tend to be spouses or partners who are not committed to the child, and may actually never have developed a reciprocal affectional relationship with the child.

Assessment of Attachment

The effective assessment of attachment hinges upon developing an individual attachment history for both the child and the parent, as well as the parent/child dyad. Differential diagnosis of attachment difficulties is important to developing a comprehensive treatment plan for the child and family.

To assist in the assessment process, the attached materials include information on the adult

attachment interview, as developed by Ainsworth. Although this is developed along with a scoring model, even without scoring it provides a wealth of clinical information useful in the assessment process. Also provided is a wide variety of factors to consider in the child's ability to develop attachments. As a particular parent/child dyad is evaluated, a list of symptoms and dynamics, which characterize the style of interaction, also emerge, and are provided.

A particular aspect of the assessment process that warrants emphasis in the evaluation of a particular parent/child relationship is the premorbid functioning of the family prior to the child's arrival. This is significant for the impact of the new relationship with the child upon family functioning. When attachment difficulties are present, family functioning often deteriorates. Without consideration of premorbid conditions, families are often blamed for causing difficulties in the child, when in fact the families' struggles are a result of the child's difficulties with attachment.

A helpful resource is the attached handout entitled, "Family Dynamics and Interventions." This handout compares and contrasts the abusive/neglectful family with foster and adoptive families along the dimensions of attachment, affection, discipline/control, the child's responses to these, and suggested interventions for each.

There are four combinations of parent/child attachments. The first is the positive reciprocal attachment. Obviously, this type of attachment is the goal of adoption and foster care. The second combination is called "I hate you" for the child who rejects a committed parent. Despite the child's rejection, the parent remains involved, but risks depression, burn-out, and extreme levels of distress. Delayed attachments are often seen in this dyad. This type is common and will work in adoption and foster care, but is quite painful for both adult and child.

The third, "Please love me" dyad includes a rejecting parent and a persistent child. This is often found in neglectful and abusive birth families, where the child's attachment to the parent persists despite repeated disappointments and rejections. The child's continued attachment to the abusive birth parent is often a basis for rejecting the adoptive family, and suggests the child has not dealt with the reality of the birth family, nor grieved its loss. This type of dyad is somewhat unusual in adoption and foster care.

Occasionally, a fourth reciprocal-rejection parent/child dyad is found, in which neither the child nor the parent feels attached. This is present in abusive and neglectful homes, as well as homes that provide only custodial care for the child. Type four, if present in foster care or adoption, will lead to disruption of the placement or dissolution of the adoption.

Applications of Attachment Theory in Adoption

The uses of attachment assessment are many. These include determining the adoptive readiness of children and their preparation for adoption. To be adoptive-ready, the child must have resolved losses so that these do not interfere with the placement. Some socialization of the child is often required to attach satisfactorily. A child's recognition of the need to find a more functional family and a willingness to engage with them is advantageous, and adoption readiness is often enhanced by the protection of attachments presently in place in the adoptive family?

A parent's readiness to attach to a child should be assessed as part of the home study process. This should include an evaluation of the parent's attachment history and capacity, knowledge of his or her own affectional needs, realistic expectations of parenting a special-needs child, and resolution of losses such as infertility.

Attachment theory suggests children should be matched with a family according to its coping and attachment styles, tolerance for rejection, need for affection, and so on. Matching along the dimensions of problem-solving styles, activity levels, and expression of affect and conflict will also enhance the capacity to develop attachments.

Responses to abuse allegations in foster and adoptive families can integrate attachment theory. Evaluation of attachments will provide clues to the likelihood that abuse, neglect, or sexual abuse has occurred. Reciprocally attached families typically do not have abuse events, nor false accusations.

The "I hate you" parent/child dyad is particularly vulnerable to false accusations made by angry, manipulative children. Types three and four, the "Please love me" and reciprocal-rejection dyads, are profiles of potentially abusive and neglectful families.

In making a decision regarding disruption of placements, attachment theory may assist again. Reciprocally attached children are unlikely to disrupt. The type-two dyad will disrupt only as a last resort, typically because this is the only way parents can seek and qualify for services needed by the child. These parents suffer tremendously if disruption is necessary, and often benefit from maintaining contact with the child after disruption. Interventions with type-two families to enhance the child's attachment will assist in preventing disruption.

Types three and four are the families in which disruption is most likely to be necessary. Often, the type-three family will use out-of-home placement in lieu of disruption. Other families may simply abandon the child, or initiate formal proceedings to disrupt or dissolve the adoption. Interventions with type-three families should promote parental awareness of the child's needs. This may include visiting the child's placement, maintaining contact, and exploring parental impediments to the attachment. Type four is such a damaged parent/child dyad that intervention should be attempted, but with modest expectations of clinical success.

Attachment theory suggests transracial and cultural placements are viable, particularly when adoption preserves an attachment already forged in a foster home. This does not minimize the need, however, to pursue culturally-like placements to assist in developing the child's identity, cultural integrity, and pride. Furthermore, because attachments often depend upon finding likenesses, efforts to place children in like-racial/cultural homes can enhance chances of successful placement.

Family preservation speaks strongly to the need to maintain birth family relationships, intervening early, often, and vigorously to prevent a child's removal from the family. The birth family has an advantage that later families will not experience in their bonding. Because of the risk involved in separation, and the loss of components of the child's identity that accompanies it, attachment theory would argue for preservation of viable attachments, enhancement of existing attachments, interventions for weak attachments, and attempts to preserve birth family ties.

Attachment theory suggests siblings attached to one another should be placed together. Because many siblings exhibit distorted attachments, separating them sometimes is necessary, if and only if, intervention to correct the attachment has been ineffectual. Contact between siblings should be maintained, with supervision as necessary to prevent dangerous interactions.

The development of a lifebook, keeping a chronicle of a child's attachments, separations, and losses, would be consistent with attachment theory. Not only would this be a vehicle to capture past attachments, but also to address and resolve losses.

Attachment theory is also pertinent to a variety of other issues extending well beyond foster care and adoption. These include visitation schedules for non-custodial parents, quality daycare for working parents, decisions about the assignment of parents in military service, and accessibility of children to parents who are being treated for medical difficulties or are incarcerated.

Treatment of Attachment Issues

Therapeutic interventions are often sought by families who are experiencing attachment difficulties. Parents who are committed to their children are most likely to seek intervention, due to perceived pain in the child or acknowledged pain in the parent. Parents involuntarily assigned to treatment obviously pose more of a difficulty. Their prognosis tends to be poor, particularly because the reciprocal nature of attachments demands their active participation in the process, adherence to interventions prescribed, and commitment to the child.

In attachment therapy, the goal is reciprocity in the parent/child relationship. The patient is actually the attachment relationship, rather than a particular individual in the parent/child dyad. Parents must be active participants, at times to the extent of serving as cotherapist. This is particularly

important, because the parents actually carry out the therapeutic work in their relationship with the child in the milieu of family life at home, not in the therapeutic setting. Parents must be empowered to become a vital part of this process. The attachment therapist guides and directs, but ideally remains a facilitator, rather than becoming another primary attachment figure in the child's life.

In attachment therapies, it is understood both parent and child are likely to reenact old attachment patterns. The ghosts of these previous attachments must be addressed and resolved. Any losses and difficulties are likely to be worked and reworked in each new developmental stage, in the child, parent, and family.

Treatment models and approaches typically fall into one of three categories. Talk, play, and other expressive forms of therapy are often used for uncovering or confronting blocks to attachment and enhancing existing attachments. Regressive therapies address the age or stage where the child's emotional development was stalled, or specific needs were not met. In this approach, parenting is focused on the targeted developmental level, in order to address the child's unmet needs.

Frequently, holding, the third category of treatment, will be integrated into the regressive therapies. Holding therapies include provocative forms that provoke rage in the child; evocative therapies, which attempt to evoke the emotions blocking attachment; and parent-initiated holdings, which are carried out in the family setting to enhance the parent/child relationship.

The process of attachment therapy essentially reenacts the attachment cycle. An attempt is made to elicit the child's emotional pain or experience that is blocking present attachments. This creates an emotionally aroused, need state. Parents experiencing their child's pain, struggles, and difficulty will be aroused to compassion and empathy. This emotional hook prompts the parent to meet the emotional needs of the child. As the child struggles with issues in therapy, the parent compassionately meets the child's emotional needs, completing the attachment cycle.

Type-one families are typically experiencing some reciprocal pain about losses and separations. Addressing this pain and mutually comforting one another enhances the attachment already in existence. For type-two families, in which the parents' pain and empathy are already considerable, therapy allows the child the opportunity to view the parents' expression and their management of psychological pain. This modeling encourages children to walk through their own pain. As the child risks sharing and is provided with comfort, he or she will benefit from the attachment cycle and enhance weakened attachments.

In the type-three family, the parent is encouraged to see the child's distress, and hopefully is moved to respond more appropriately in a comforting, protective, and nurturing role. With type-four families, the goal is to promote any sharing and an appropriate response. Again, emphasis should be maintained on realistic expectations with such damaged families.

The first stage of attachment therapy typically involves establishing rapport with the parents, to enlist their assistance by becoming cotherapists in the process. Often with the highly disturbed child, the therapist's avoidance of rapport-building with the child will actually enhance rapport with the parents. Manipulative, exploitive children try to seduce their therapist to protect themselves and divide the family further. An assessment stage follows, and is often integrated into the rapport-building stage.

Middle stages of attachment therapies address the themes, content, and attachment issues interfering with the present parent/child relationship. These stages include addressing abuse and sexual abuse issues, loss and separation, impact of past trauma on present relationships, adjustment of the parent and child to one another, enhanced understanding of each other, and cultural and racial differences.

Indicators for termination of therapy include a reduction in the intensity of the therapy. Oftentimes the parent feels better, while the child acts better outside the therapy session. Also when the child begins to enjoy the therapist, it is often an indication that termination is imminent.

A return to therapy is often indicated by the return or increase of parental frustration. Old behaviors may reemerge in the child, the child may make new disclosures of trauma, anniversary reac-

tions may occur, or developmental or other crises in the child's or family's life may demand that old issues be reworked in a new context.

Resistance to attachment therapies is addressed in a series of materials at the end of this article. Specific resistances found in adoptive parents, adoptive children, and functional children in adoptive families are addressed on three pages with those titles. These resistances are identified, dynamics described, and the therapist's response articulated.

Cautions in Attachment Therapies

Contraindications for attachment therapies may include the following: A psychotic child or parent; a severely unattached child, who will often require inpatient treatment; some brain-damaged children who are unable to process the information in such a way that they can benefit; most adolescents, who are attempting to disengage at the same time, so that asking them to attach works at cross-purposes with the developmental demands of their age; uncooperative, dysfunctional parents; absence of a committed family; and parents who do not approve of the techniques and interventions typically used in attachment therapies.

This last factor is critical, as the holding therapies in particular are controversial. Even within the attachment community there is controversy, about the more intrusive and provocative techniques included in some holding therapies. Because holding therapies are a form of physical restraint, foster parents, and adoptive parents who are still under supervision, should gain written approval for the use of these techniques from their caseworker and a written recommendation by a therapist. Parents should also seek training and supervision in these techniques.

Therapists wishing to utilize holding techniques should seek training, read the resource materials available, and practice under the supervision of another trained holding therapist. The materials are not sufficient to begin holding therapies, although attachment work can be informed by this information.[1]

An effort to define the Code of Ethics and standards of practice has been conducted by ATTACh organization. For copies of the materials, please contact the ATTACh office at the number below. Because malpractice carriers often exclude therapies that involve physical contact with the client, care should also be exercised that the clinician has coverage, or that clients are informed that their therapy will not be covered under that malpractice clause.

To ensure ongoing access to holding therapies, professionals and parents alike are encouraged to utilize good judgment, ethical conduct, and sound practice to protect this tool, which is extremely powerful, yet vulnerable to misunderstanding, misinterpretation, and misuse.

In closing, a caveat regarding self-care for the professional involved in attachment therapies. It is recommended that attachment therapists evaluate their own attachment history and style, as this informs clinical work, judgments, and emotional responses during treatment of attachment issues. It is important to examine responses to separation and loss, as well as coping styles for those losses. Internal monitoring for countertransference surrounding these issues is necessary. Part of this will be finding one's tolerance for pain and recognizing that, to deal with attachment issues, a therapist must be prepared to handle great pain and sorrow. To balance this, attachment therapists should seek out sources of joy and intimacy, and should maintain connections that are healthy and functional. Naturally, seeking consultation, supervision assistance, and treatment as needed, is necessary to maintaining good judgment and practice. Finally, spiritual beliefs can help us manage the emotional challenges of this work.

[1]Further training in holding therapies is available through Forest Heights Lodge, in Evergreen, Colorado (303/674-6681); Martha Welch, M.D. (203/661-1413); Evergreen Consultants (303/674-5603); and The Attachment Center at Evergreen (303/674-1910). In addition, the annual ATTACh conference represents training opportunities in a variety of approaches. For information on upcoming conferences, the ATTACh organization can be contacted at 214/247-2329.

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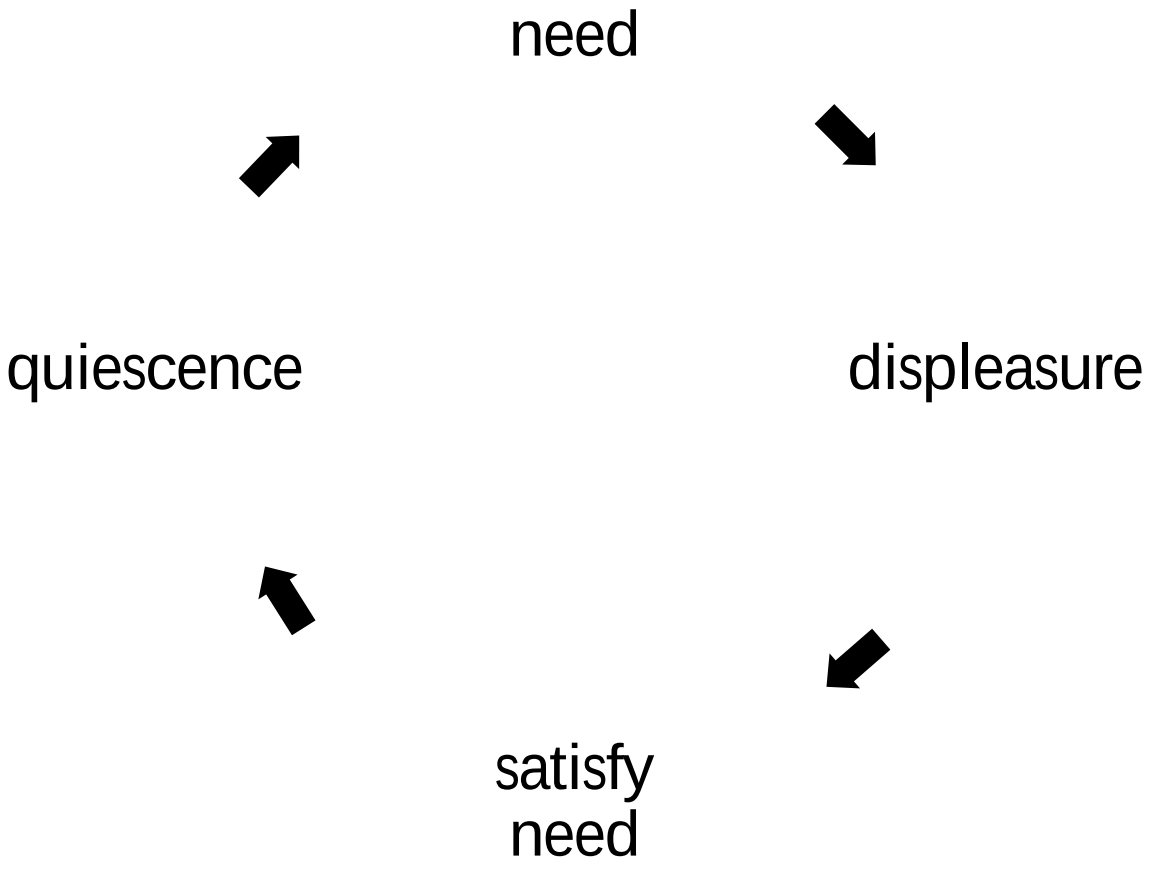
HANDOUT # 9-1 The Arousal -Relaxation Cycle

Source: Vera Fahlberg, M.D.



HANDOUT # 9-2 Family Dynamics and Interventions

	Abusive/Neglectful	Foster	Adoptive
Attachment	• Weak or nonexistent • Distorted • At risk, periods of child's development based on parental reenactment • Parental capacity to attach • Separations	• Variable—strong to non-existent • Short term commitment ot love • Flexibility • Willingness to release child • Accepting of problems	• Long-term commitment to child • View child as own • Examine reciprocal attachments • Variable, depending on child's acceptance of family's love
Affection	• Desire to receive, not provide • Affection sought with sexual partners, not child • Substitution of child for adult partner or parent • Conditional • Lack of intimacy	• Want to provide, fewer expectations of receiving affections • Needs met outside parent/child relationship • Unconditional, but with limits on conduct • Diluted intimacy	• Expect reciprocity of affection • Expressive of affection • Desire to provide love lost • Unconditional, may move to conditional love • Intensity of intimacy
Discipline/ Control	• Excessive controls • Lack of controls • Variable and inappropriate controls	• Consistency in discipline with structure, organiza-tion, expectations, formal behavior management techniques or programs • Detached limit setting, little ego-involvement in misconduct	• Expectations of respect, acceptance of authority • Discipline with love • Ego invested in child's conduct
Results in Child	• Inability or difficulty establishing attachments • Distrusts of adults • Distorted attachments • Identification of love, affection, difference from norm • Seeking of affection based on original patterns • Disrespect for authority. Little self-control	• Stabilize behaviors • Able to accomodate to authority, discipline • Willing to engage on limited basis with parent OR • Behaviors secondary to loss and separation disrupt placement • Need for controls exceeds parents' ability to exert	• Stabilization, security OR • Resentful of past losses and sabotage placement rejecting parents OR • Unable to handle intimacy, revert to old dynamics

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	Abuse/Neglectful	Foster	Adoptive
Interventions	• Enhance functional attachments between parent and child • Protect, keep intact healthy attachments • Improve parenting (discipline, expression of affection, roles in family) • Intervene with child to help attachment, medication, treatment • Frequent contact if in foster care • Speedy return, as appropriate • Admire and encourage appropriate forms of parenting demonstrated • Predict replay of loss, abuse dynamics from own childhood	• Prepare parents for child • Assist in letting go of child • Support parents through treatment for child, consultation, recommendations for managing behaviors • Maintain relationship after separation • Help parent accommodate to child's need, treatment, etc. • Teach child how to function in a family • Predict replay of loss, abuse dynamics from own childhood	• Match child and parent carefully • Articulate "rules" of family system • Prepare parents through education, child's history, parenting skills • Lower expectations of returned affection • Empower to discipline • Avoid ego investment in child's conduct • Enhance attachments • Diminish intimacy and intimacy demands • Predict replay of loss, abuse and dynamics from childhood

HANDOUT # 9-3 Adoptive Children

Resistance	Dynamics	Response
Denial of feelings	Consider age of child (latency especially)	Confront
	Early age at trauma, no memories	Use records, lifebook to tell story
Poor Attachment	Little motivation to change, address issues	Attachment therapies
Fantasy "story"	Nondisclosure of thoughts, fantasies	Elicit fantasy material directly or indirectly
"I don't know"	"I don't want to talk about it"	Disallow response
Disability, hyperactivity	Avoid feelings	Control child, use holding techniques
Denial of experiences	"If they knew about me, they'd reject me"	Open up family communication, check it out
Low self-esteem, self-hatred	Not worthy of love, acceptance	Assist in positive self statements, parents' positive input
Failure to take responsibility—blaming	Fear/attachment issues/unsocialized	Reassurance/attachment therapies/teaching, limit-setting

HANDOUT # 9-4 Adoptive Parents

Resistance	Dynamics	Therapist Response
Who has the problem?	Reluctant to seek services	Clearly label problem
Who needs the change?	Depression, anger, isolation, alienation	Support family, encourage self-esteem in parents
Infertility: Why did you adopt?	Brittle defensiveness vs. reworking	Establish relationship **before** probing
Others' authority over their family building. Fears of losing child.	Anger	Reassurance, help establish their role as parent
"Secrets"	Excessive distress, "stuck" irrationality, inability to respond	Gently help disclose secrets
Denial in early stages of placement—"We can fix it"	Persistence, frustration, low self-esteem	Help rework old issues, explain their predictability
In-control, competent, well-informed/educated parents—expert on **their** child	Erratic attendance, using information to "play therapist"	"Normalize the family's feeling/response
		"Use" competence to child's benefit
		Link to peers
		Medication for depression, anxiety

HANDOUT # 9-5 Functional Children in Adoptive Families

Resistance	Dynamics	Response
"It's not so bad" or silence, reluctance to speak up	Protecting parents from more pain, guilt	Open up communication, acknowledge child's pain
"I hate him, get him out of here"	To much damage done, too little intervention	Intervene to reduce pain and conflict. (Often get him out of there)
Protection of troubled sibling	Senses the pain underlying behavior and wants to rescue	Acknowledge pain and help functional child grasp need for sibling to cope differently
Avoidance of sibling	Guilt for participating in misconduct—often sexual	Expose the conduct, addressing it directly, reassuring functional child
"She's not my sister"	Rejection of sibling because of embarrassment of lack of child's respect for family (i.e., attachments)	Help child set appropriate boundaries and distance

HANDOUT # 9-6 Adult Attachment Interview

(From M. Main and Teresa Nezworski)

Format—Structured Interview

- Give five adjectives to describe relationship to mother and to father
- What made you chose those descriptors?
- Brief autobiographical episode to support evaluation—specify, supportive, contradictory
- What did you do in childhood when you felt/experienced…

  upset loss
  ill abuse
  rejected separation
  hurt

- Why do you think your parent behaved in the way you remember?

* Has your relationship with your mother/father changed in a major way since childhood?

- Describe current relationship with mother/father

* What kind of influence has this childhood experience had on:

  your personality
  current behavior
  future parenting

HANDOUT # 9-7 Assessing Adoptive Children and Families

Adoptive Child

- Birthmother's prenatal care, ETOH, drugs
- Delivery complications
- Neonatal difficulties
- Response to relinquishment
- Kind of infant: temperament, eating, sleeping problems
- Early relationship if remained with birth parents
- Medical and psychiatric history of birthparents
- Developmental stages at appropriate times
- Health injuries
- School history
- Traumas and when they occurred
- Attachment
- Role in family
- Behaviors, problems, strengths
- Perception of presenting problems(s)

Adoptive Parents

- Personal history
  - Childhood traumas, mental/health problems
  - Experience with adoption
- Who wanted to adopt and why
- Strengths, weaknesses in marriage
- Perception of presenting problem(s)
  - What solutions have been tried/results
  - History of problem(s)

Family Dynamics

- Family functioning prior to adoption
- Reactions to problems
- Expectations of each other/realism, disappointment
- Fantasies about each other/reality?
- Coping skills, resources, supports
- Level of denial/awareness of adoptive issues
- Is child recreating a dysfunctional first family?
- What is the nature of mutual attachments

HANDOUT # 9-8 Assessing Attachment

I. Attachment history-taking

A. Child and age(s) at:
- Illnesses, physical needs
- Separations
- Temperament
- Caretaker availability, responsivity
- Developmental milestones
- Prenatal exposure to substances

B. Parent:
- Age at separation from own parent(s)
- Viability and nature of present attachments
- Ability to be available, responsive to child
- Maturity level (impulse control, judgement, ability to delay gratification, empathy)

C. History of current parent-child relationship
- Circumstances surrounding its initiation
- Stressors and supports to family
- Expectations of foster, adoptive role
- Child's expectation of foster care or adoption
- Honeymoon period
- Testing period
- Integration period
- Questioning commitment
- Resolution phase

II. Attachment behaviors

A. Positive Signs:
- Eye contact
- Affection expressed and give
- Spontaneity in expression of affect
- Genuine "thank you's" and "I'm sorry"
- Desire to please
- Finding similarities

B. Negative Signs:
- Manipulation through the use of affection
- Avoidance of eye contact
- Little affect, except anger, rage
- Avoidance of, or wooden acceptance of affection
- Superficially charming with strangers
- Dangerous acting-out behaviors
- Lack of remorse
- Unable to benefit from punishment, reward
- Uncommunicative

C. Signs of incomplete Grief for Past Attachments:
- Ambivalent behaviors
- Insecure, clingy behavior
- Explosive rage, followed by weeping
- Testing love, commitment of caretakers
- Sad affect in quiet moments
- Anxieties, fears, concerns
- Immaturity in emotional needs

III. Family Dynamics

A. Well Attached:

"It's as if they were born to us"

"We can't imagine life without her"

"We fell in love with him"

"It'll kill us if anything else happens to this kid"

B. Poor Attachment

Anger at child

Marital disharmony

Blaming child

Little empathy for child, or inability to behave empathetically

Child detached, angry

Child treats family members as objects

"Healthy" children hate or resent sibling

"Come get this kid"

C. Struggling attachment:

Parents confused, insecure

Parents committed but overwhelmed by child's needs or difficulties

Child alternately angry and loving

Child isolates or stays on fringe

Family turbulent, but optimistic

"Help me with this kid"

IV. Assessment Instruments

Burk's Behavior Rating Scales

Achenbach Child Behavior Checklist

Parenting Stress Index

Family Environment Scale

FIRO-B

Adoptive Children With Developmental Disabilities

10

Marjorie Grace, LCSW

Introduction

Adopted children with developmental disabilities frequently present many more challenges to a family than those without the developmental disability. There are many similarities emotionally to being disabled and to being adopted. When disabled children are also adopted, these issues impact them doubly hard. Attachment issues are made even more complex. The core issues that every developmentally disabled person experiences can be compared to those of the adoptee. These core issues (Kaplan-Roszia & Silverstein, 1988) common to adoption triad members are loss, rejection, shame/guilt, grief, intimacy, identity, and control. All of the areas resulting from being handicapped are compounded, intensified and "doubled" as a result of also being adopted.

Developmental disabilities include a wide range of neurological anomalies such as mental retardation, cerebral palsy, autism, and seizure disorders. In this article, references to developmental disability are limited to those delays severe enough to significantly influence a child's normal emotional, social, and academic development because of neurological interference. Further, only those children whose parents are likely to seek a psychotherapist are addressed here, since this article is written for therapists.

There are two kinds of parents who adopt children with significant delays. The first group is the family that knew at the time of adoption that their child had significant developmental delays. These parents are usually already familiar with handicaps and the resources potentially available through medical and educational agencies, and generally would seek help through those agencies. The parents most likely to appear for psychotherapy are parents who think the child will be normal, either because of little accurate information at placement or because the parents are unwilling to accept the diagnosis. With a child who has mild delays or no physical abnormalities, it is difficult for the inexperienced person to grasp that the delay exists, especially when the child is younger. With the second, denial type of parent response, the adoptive parents' reaction is similar to the reaction of birth parents when they first learn there is a developmental disability.

This article covers adoption issues of individuals with mild to moderate developmental disabilities, whose adoptive parents may not have expected to parent a child with developmental delays, and who are more likely to appear in the therapist's office seeking help for the child to alleviate the "emotional overlay." Or, perhaps the parents themselves come because they do not fully believe the diagnosis and seek other explanations and treatment.

The "Double Whammy"

The one significant factor that stands out above all others is that the adoptee has a "double whammy": a two-fold impact as the adoption and the impairments influence his/her growth and development. Emotional reaction to these two life challenges may be similar when experienced separately, but the main issue needing to be addressed can be very unclear when the adoptee is also developmentally disabled. The source of the presenting emotional symptoms is more confused. For example, is the child's behavior a response to being different because of the handicap or because of not

being born into the family? Another example relates to self-esteem issues. Is the child feeling bad about himself because he was given up by his birth mother and is wondering, "Is there something wrong with me?" or because he is not able to do everything that other kids his age can do? When the disability involves limited communication skills the problem is further compounded.

In one case, Kevin was born 2 months premature and was abandoned in a motel room. His temperature had dropped several degrees. Kevin was diagnosed with cerebral palsy, had multiple placements, and was a failure-to-thrive baby. He came to his adoptive home at 5 months, where he blossomed. His early preschool experience was very positive, as Kevin was in specialized preschool with children who had severe handicaps, and he became a helper. He was very outgoing and had many friends. However when he was placed in regular classes in first grade, he began to have trouble socially. By then, Kevin was 9 years old; he had moderate levels of physical impairment of one arm/hand and leg. Academically he was about a year behind. He had difficulty making friends, had low self-esteem and made no eye contact. He became withdrawn, quiet, and was known to make up "tall tales" about himself. Sometimes he would sob uncontrollably and not be able to say what he was crying about. He had very good verbal skills and was securely attached to his mom and dad. Kevin had never dealt with his feelings about his adoption when I first met him. During therapy, Kevin learned his adoption story and worked through his feelings. Eventually he was able to reveal the reasons he had difficulty making friends. He stated that kids need to *find him* on the playground. His whole world changed when he was able to see that if he stood by the edge of a game in progress instead of hiding out, perhaps he'd be invited to play. When he completed therapy, Kevin was being included in playground games, looking at people when he talked, and obviously feeling good about himself once more.

Was his low self-esteem and lack of problem-solving skills due to adoption or to being physically impaired and intellectually delayed? Perhaps we will never really know the answer. However, it wasn't until after he completed his adoption work that he was ready to tackle the friendship problem. Kevin was impacted from both directions at once by his developmental disabilities and by his adoption experience.

Attachment

Another issue in adoption that has a double impact on the child is developing secure attachment. Adoption itself frequently leads to attachment difficulties, and the child sometimes needs outside help accepting and trusting parents chosen for him by someone else. Yet we also know that developmental disabilities alone can lead to attachment difficulties when the child is not able to signal his/her needs to the caregiver in a way that the caregiver can respond to and meet those needs. Similarly, attachment difficulties often lead to developmental disabilities. When there are attachment problems in disabled adoptees, the cause can be from adoption issues alone, where the child seems essentially to say, "No, thanks, you'll not be my parent," or it can be caused by developmental delays when the child doesn't signal, isn't able to signal or the parent misreads the signal of the child's needs. A child prenatally exposed to drugs may develop delays beyond those caused by the drugs, if attachment concerns are not addressed.

In such a case, Kelly was born with cocaine and alcohol in her system and was placed with an experienced foster mother who had several babies. She had eating problems where sucking was painful. She also cried when she was picked up, but would quiet when placed alone in her crib. At 16 months, she was placed in her adoptive family. She weighed only half that of other children her age, had eating problems, screamed when she was held, and would frequently try to hurt herself and hit others, especially her mother. At placement, her former foster mother said that she was "one baby she could never seem to reach." Kelly was 3 months delayed in most areas and had been receiving early intervention/developmental disabilities services since birth. She did not respond to her new family, who were aware of attachment issues in adoption. Four months after initiating attachment therapy, she became more willing to accept snuggling, and allowed parents to hold her bottle. Language development rapidly increased, and by 24 months she was on task in all developmental areas. She had

stopped hurting herself and began being nurturing to her dolls. She gave eye contact freely and improved dramatically in her willingness to be parented. Without intervention to correct the attachment problems, this adopted toddler was headed for lifelong developmental disabilities and the inability to have healthy relationships or parent healthy children.

Kelly's first foster mother was unable to read her signals and respond in a way to facilitate attachment, even though she was an older experienced foster mother. Kelly's delays were not improving in her adoptive family. She lost ground during the early months in her adoptive placement because of attachment problems. The adoptive mother read her signals well, but lacked the additional training to turn the attachment process around until she was helped in therapy. You would not be able to pick this 33-month-old child out of a group of toddlers today.

Core Issues of Adoption

A third area where we see a doubling effect is in the seven core issues in adoption. All of these issues of adoption are compounded by additional core issues related to developmental delays, as summarized in the attached chart. Loss, rejection, shame/guilt, grief, intimacy, identity, and control are more complicated than for those unaffected by delays. Persons with developmental disabilities share the loss of normal abilities, experience rejection of self and by others, feel the shame of being defective or "less than" (normal), grieve the loss over their lifetimes and have trouble developing intimate relationships because they are often socially excluded. They have identity issues such as "feeling inferior" to peers, and feel different as a result. They have issues over control throughout their lives because of actual limitations.

In addition to the *loss* of history as described by Kaplan and Silverstein, the delayed adoptee loses "normal" life experiences as a fully independent person. Kevin cannot play baseball on the playground because he can't run and is losing the normal childhood experience of free play with peers. Further loss is of his ability to determine his own level of learning. Kevin cannot choose to learn to run fast. These losses have a doubling effect as the adoption losses intersect the losses from his delays. For the birth parent and adopted parent, their additional loss is that of being parents of the normal child (fantasy child) they could have had, and related fantasy relationships.

Delayed adoptees additionally may feel twice *rejected* by their birth mothers because they are intellectually or physically handicapped. As teens, delayed youngsters are usually rejected for dates by normal peers. A birth mother may sometimes reject herself because she produced a "defective child," and adoptive mothers often reject others because of overinvolvement with the handicapped child. They are also often ostracized because of the child they decide to parent.

Adoptees and their parents experience both the *shame and guilt* associated with being adopted and that connected to developmental delays. For the adoptee, the shame ("I am different") is intensified. Not only did he come to his family in a different way, through adoption, resulting in immense shame, but his differentness is forever with him because he learns more slowly and needs special help during his childhood and throughout his life. The birth parent may have intensified shame for having given up a handicapped child, as well as guilt and shame for having produced a child with "defects." For adoptive parents, the shame of infertility is compounded by the same normal reactions experienced by birth parents of disabled children: that somehow they've been punished, could have sought help sooner, or could have parented in a different way, thus lessening the delays.

Delayed adoptees may express *grief* in the form of physical ailments after placement. Their grief is often overlooked as coming from either their adoption or the delays. As the adoptee matures, grieving may be blocked because of not knowing or accepting the nature of the handicap. Denial is common ("I'm a slow learner") as is a way of protecting and insulating against lifelong taunts by peers. For the birth parent, grief over both giving up a child to adoption and producing a defective child may be blocked by the shame and lack of social sanctions for grieving these losses. The effect is compounded by having both lost a child and the loss of giving birth to a normal child. Most parents of non-adopted developmentally disabled children experience the grief that is often called "chronic sorrow" and

which is culturally unacceptable to express because of its pervasiveness. The adoptive parent, too, sometimes experiences the unresolvable grief of the child's unfolding disabilities, especially at transitional times in the child's development. The parent may experience as rejection the adoptee's grief and diminished ability to respond.

Mary, mildly retarded and adopted, was told by her birth father that he would come back and get her when she was placed in foster care at age six. At age 12 she was adopted by the last in a series of several sets of foster parents. She was never able to tell anyone of her sadness, or to grieve, when year after year her birth father didn't come back. She hates her adopted mother, (she calls her "step mom") who didn't know how to meet her emotional needs. Mary is 27 now, and has trouble parenting her 9-month-old daughter. She also smothers her husband because she fears he will abandon her every time he leaves home without her. Mary's mother was not prepared to help a 12-year-old deal with her adoption issues because she had not grieved her own losses. The delays Mary has and her emancipation at 18 from an uninformed adoptive family did not prepare her for the difficulty of parenting an infant or being in an adult relationship with a husband.

Many parents cannot get beyond completion of school in planning for the future of their child; consequently, the child (now adult) is ill-prepared for living away from the parents as he/she reaches adulthood. "Chronic sorrow" (unresolved grief) interferes with preparation for the normal independence of adulthood.

Adoptees with disabilities sometimes experience complicated difficulties with *intimacy,* as their languag, and their ability to process and understand interpersonal experience can diminish their ability to fully express how they feel. In adolescence they are more limited in opportunities to have close intimate peer relationships such as dating and normal teen activities (Melina, 1989). The birth parent experiences the impact of avoiding intimacy because it is equated with the beginning of psychological pain (conception of a child with a disability). The adoptive parents can be affected by physical/emotional exhaustion over caring for a child with disabilities, interfering with continuation of intimacy. Or their overcompensating to close the gap in the child's capacity to verbalize may lead to misinterpretation of the child's true feelings.

An adoptee's *identity* as different is multiplied for the adoptee with delays, because the handicap has contributed in tangible ways to a differentness in ability. His/her self may be experienced as "inferior." Development of an identity as a separate adult with full social privileges is frequently delayed, or nonexistent, often because of parental protection or social responses. This can greatly impact an adoptee's sense of self-worth. For the birth parent, identity as a parent to the relinquished child, which goes on without knowledge, is intersected with the diminished sense of self-worth as a parent of a child with "defects" and as possessing defective genes and/or impaired reproductive ability. Adoptive parents of a handicapped child must incorporate not only the diminished sense of continuity of self, but also the additional shift in ability from "ideal" parent to parent of defective child.

The last of the core issues, *control*, is intensified as the adoptee experiences limitations from having handicaps. Not only was he/she not able to control who he/she had as parents through an adult's decisions for the adoption, but he/she also has no control over her own life decisions and the level of independence she can achieve. Birth parent issues around control are increased due to the inability of the parent to prevent the handicap, and hence the lack of influence on the potential course the child's life takes because of handicap limitations. The adoptive parents may experience diminished control over influencing their child's growth towards full independence as an adult. In a natural response to the disability, adopting parents must ride a fine line between following their protective instincts and helping the child achieve independence. A frequent response is overprotection during childhood, which extends into the adult years and increases dependency, sometimes more than necessary.

Summary

In all parts of life, as in the emotional core issues of adoption, we see how intensified, interrelated, and more complex the influences are on growth and development of the adopted child who also has significant developmental delays. Frequently, the handicap takes front-line importance and of necessity is separately addressed. Families become involved with medical/educational help because those issues more obviously take precedence. For example, when caring for a child with cerebral palsy requires exhaustive amounts of extra time and energy, as well as frequent medical consultations, often hospitalization for corrective surgery or respiratory infections, adoption issues are often set aside. However, as we saw with Kevin, the child needs help understanding his adoption so that he can process his feelings and not get stuck emotionally.

It is important for adoptive parents to understand the intensified impact of both adoption and the handicap itself on relationships, behavior, self-esteem, learning, and on the child's reaching his/her full potential as an adult. Without addressing the adoption issues, the adoptee with a handicap is just as emotionally stuck as the adoptee without handicaps who has unresolved adoption issues.

References

Kaplan-Roszia, S., & Silverstein, D.(pps. 45-53) (1988)"The Seven Core Issues in Adoption." In Tilbor, Hornby, & Boggis (eds.) *Working with Older Adoptees*. Portland, ME: University of Southern Maine.

Melina, L. R. (Ed.). (1989). *Adopted child*. Vol. 8, No. 11. p. 5.

HANDOUT #10-1 Seven Core Issues in Adoption and Developmental Disabilities[1]

Non-starred material relates to issues in adoption.
Starred (* and ★) items refer to developmental disability issues.

	Adoptee	Birth Parent	Adoptive Parent
Loss	Loss of biological, genic, cultural history. Issues of holding on and letting go. Fear of abandonment.	Ruminates about lost child. Initial loss merges with other life events; leads to social isolation, changes in body & self, relationship losses.	Infertility sometimes equated with loss of self & immortality. Issues of entitlement lead to fear of loss of child and overprotection.
DD:	* Loss of familiar sights, odors, touch (concrete level). ★Loss of "normal" life as fully independent person. ★Loss of ability to determine and control level of learning, control muscles (CP), self (seizures). ★DD adoptee has double losses.	* Loss of life as it was before life-transforming event. * Loss of fantasy relationship/child. ★Loss of "normal healthy child."	* Loss of parts of adopted child's life. * Loss of fantasy relationship. ★Loss of "normal" child.
Rejection	Personalizes placement for adoption as rejection. Issues of self-esteem. Can only be "chosen" if first rejected. Anticipates rejection. Misreads/misperceives situations.	Rejects self as irresponsible, unworthy because permitted adoption. Turns these feelings against self as deserving. Comes to expect & cause rejection.	Ostracized because of procreation difficulties.
DD:	★All of above are double because of handicap. ★Feels rejected by birth mother because of handicap. ★Teens rejected as dates by peers.	★As above, additional rejection of self because of producing "defective" child.	* Ostracized because of children decided to parent. May scapegoat partner (due to procreational difficulties.) Expects rejection. Emotionally expels adoptee to avoid anticipated rejection. ★ Rejects others because of overinvolvement with handicapped child.

[1]Non-starred items are from Kaplan-Roszia, S., & Silverstein, D.(pps. 45-53) (1988)"The Seven Core Issues in Adoption." In Tilbor, Hornby, & Boggis (eds.) *Working with Older Adoptees*. Portland, ME: University of Southern Maine. Adapted with permission.

*Additional material from LAS/CDD Program.

★ Additional material from author.

	Adoptee	Birth Parent	Adoptive Parent
Guilt/ Shame	Shame of being different. May take defensive stance/ anger. Deserving misfortune.	Party to guilty secret. Shame/guilt for placing child. Judged by others. Double bind: not OK to keep child, not OK to place.	Shame of infertility. May believe childlessness is curse or punishment. Religious crisis.
DD:	★Double shame of being "twice different" (adopted & delayed).	★If handicap due to abuse or neglect, guilt over producing child w/ handicap. ★Imagined or real guilt over proper care during pregnancy as cause for DD.	* Guilt over rejoicing at child's entrance into family while observing grief of birth parents/family/adoptee * Guilt over entitlement gestures (i.e., name changes).
Grief	Grief may be overlooked in childhood, blocked adult leading to depression/acting out. May grieve lack of "fit" in adoptive family.	Grief acceptable only for a short period but may be delayed 10-15 years. Lack of rituals for mourning. Sense of shame blocks grief work.	Must grieve loss of "fantasy" child. Unresolved grief may block attachment to adoptee. May experience adoptee's grief as rejection.
DD:	* Grief may take form of physical ailments after placement. ★Grief over not knowing or accepting cause or denial of handicap; blocks emotional growth.	★ Shame of producing "defective" baby also blocks grief work.	★May experience adoptee's diminished neurological ability to respond as rejection (and grieve loss of love).
Intimacy	Fear of getting close and risk reenacting earlier losses. Concerns over possible incest. Bonding issues may lower capacity for intimacy.	Difficulty resolving issues about release with other birth parent may interfere with future relationships. May equate intimacy with loss.	Unresolved grief over losses may lead to intimacy/marital problems. May avoid closeness with adoptee to avoid loss.
DD:	★Diminished ability to fully express feelings. ★Teens' opportunities more limited for intimate relationships.	* May equate physical intimacy with beginning of psychological pain (i.e., conception of child with disability) and may avoid it. * Fear of getting close and reenacting pain of losing child.	* Physical/emotional exhaustion over care of child with disability may interfere with continuation of intimacy. ★Overcompensating to close gap in child's capacity to verbalize may lead to misinterpretation of child's true feelings.

Continued

	Adoptee	Birth Parent	Adoptive Parent
Identity	Deficits in information may impede integration of identity. May see search for identity in early pregnancies, extreme behaviors to create sense of belonging.	Child as part of identity goes on without knowledge.	Experiences diminished sense of continuity of self.
DD:	★Differentness compounded (handicapped & adopted). ★ May see self as "inferior" because not physically perfect. ★ "Dehumanization " by society impairs normal sexual identity formation.	* How child identified now beyond birth parent control (i.e., name alteration). Diminished sense of self-worth. May interfere with future parenting desires. ★Sees parenting self as having defective genes or reproductive ability, defective biological parent.	* Psychologically, birth family now part of landscape. * Boundary issues emerge. Is and is not parent. ★"Ideal" parent shifts to parent of defective child.
Control	Adoption alters life course. Not party to initial decisions. Haphazard nature of adoption removes cause & effect continuum.	Relinquishment seen as out of control, disjunctive event. Interrupts drive for self actualization.	Adoption experiences lead to "learned helplessness." Sense of mastery linked to procreation. Lacks generativity.
DD:	★DD limits ability to have total control of own life decisions and level of independence.	* Struggle for control over adoption process (to minimize pain) can impede placement process & delay grief work. ★"Defect" in child out of parent's control to prevent.	* Fears loss of control over who will be included in family unit (issues of inclusiveness & boundary-setting). ★Diminished control over influencing child's growth toward full independence as adult. ★May overprotect.

The Large Adoptive Family: A Special Kind of "Normal"[1]

11

Barbara Tremitiere, Ph.D., ACSW, LCSW

Introduction

The percentage of families with four or more children has been decreasing steadily, as reflected in Census Bureau reports dating back to 1900. Rational decisions about the number of children one will parent is thought by some to correspond to a concept of "costs" or what parents must sacrifice in order to obtain what they perceive as benefits to be derived from having and raising children. Those families who go beyond the range of two to four children are assumed to have special reasons for doing so. One of these "special reasons" seems to be a trend in large adoptive families that have been created by choice in recent years.

One resource that reflected this trend was *Because We Care So Much* (Tremitiere, 1973-1988), a newsletter distributed without charge by Tressler Lutheran Services to adoptive families across the United States who had five or more children. By 1988, the circulation of this newsletter grew to over 2,000 families. Many of these families had adopted after having several birth children and asked to adopt children who were not easily placed and for whom there might well have been no other home readily available.

Because they were unusual, both in family size and in request, these families often had negative reactions from the agencies to whom they had applied for children, as well as from their families, friends, and communities.

As these adoptions continued to occur, two very specific situations began to develop. First, many agencies seized this opportunity to place waiting children as quickly as possible into adoptive homes, often without adequate pre-placement planning and/or post-placement support. Second, in many cases, problems began to surface in families as the children grew older and their difficult areas became more evident. Some families found themselves with children whose mental health problems intensified, often requiring temporary placement outside the home. Others discovered that severe attachment problems could cause chaos in a family situation. For some, this even led to false child abuse charges being made against the parents. Questions began to arise, from agencies and families alike. How were large families and large adoptive families both alike and different? What could be learned from the qualities and experiences that appeared to be similar? What new understanding would be needed in order to comprehend and impact the perceived differences?

This paper briefly addresses and explores these questions and discusses crowding, sibling interaction, the applicability of systems theory, the significance and implications of the multi-cultural makeup of many of these families, projects and suggestions for enhancing successful experiences in large adoptive families, and conclusions and implications for agency and family decision-making.

Large Families/Large Adoptive Families

In comparing large families and large adoptive families in our society today, there are many interesting similarities. Are there times when the interests of some members of the family must necessarily be sacrificed to satisfy the interests of others, both emotionally and financially? This appears to

[1]Summarizes book of the same title and author, 1994, York, PA: One Another Publications.

be true in both groups of large families. Whether referring to parent-time, energy, demands, economic constraints, the endless tasks of maintaining a household, or the daily struggle for survival, families reported learning to live with "imperfection" or "learning to strike an effective compromise with reality." This compromise often included sharing household duties and child-care responsibilities with children in the family.

While the logistics of parenting a large adoptive family are often quite similar to those of parenting a large biological family, there are some notable differences. One of these differences is the composition of the majority of the large adoptive families. Many of these families had integrated children into their family structure who were older, had mental or physical disabilities and/or behavior problems, and were of different ethnic or racial backgrounds.

Another difference is that society tends to see large adoptive families as different than large birth families and to impose value judgments on them. For example, birth families don't have to convince caseworkers or judges that they can handle more children before adding to their families! Large adoptive families are always judged and evaluated by other people's family size limitations and rarely are given the opportunity or credit for the ability to impose their own. Many families resented this restrictive situation. The imposed restrictions and the quality/quantity debate still permeate large adoptive family decisions, even though the stability that these families have been able to provide for many waiting children is documented beyond debate.

Perhaps part of the problem lies in the differences that arise when a child joins a family in other ways than being born into it. For example, children in large adoptive families often have to cope with siblings who come into their family out of birth order, often pushing them out of their own perceived status and role. They often find themselves in the role of caretaker child for siblings that they have little idea of how to control.

Large families also tend to initiate and perpetuate "crowding" effects. Often used as a last desperate resource for a stressed agency with a difficult child to place, these families tend to grow in unplanned ways. Often children are placed who are the same age as children already in the family. Most times it is necessary for rooms and personal space to be shared. Sharing of turf and possessions becomes a control issue. Privacy, even in the bathroom, becomes a luxury. Children seldom have an opportunity to be alone. Tension, discomfort, anxiety, irritation, anger, and aggression may well be their responses. Parents need to be aware that each child reacts differently to the effects of crowding. For some children, crowding is a blessing, as they can blend into the group and their actions and responses are less closely monitored. For others, it brings out very negative responses. Creative solutions, such as subdivided rooms and locked areas for children's possessions, can be effective. In both birth and adoptive families, many of the effects of crowding problems are very real, both for parents and for children. Complexities are created for everyone when families elect to add more children and opt for large family living.

Systems Theory

When one accepts the position that the fate of the individual is inexorably bound to the destiny of the intimate social network of which he or she is a part, the argument between individualism and familism melts away. One cannot consider the individual apart from his or her intimate environment. (Hartman, 1979, p. 7)

Any family system, then, is composed of connecting relationships. To study the family as a system, one must see the various connections between the individualized persons and how they interact. Each person within the system has his own unique systemic individuality as well as carrying an imprint of the whole family system. I am my family as well as whatever uniqueness I have actualized as a person. I am individual and group simultaneously. (Bradshaw, 1988, p. 28)

Looking closely at large families and how they interact and function, through the eyes of family members, Bossard (1956) concluded that large families, by their very nature and complexities, had distinguishing characteristics totally unlike any other type of identified family systems. These characteristics, in Bossard's estimation, included:

1. Children added "as they happen"—not planned or scheduled.
2. Parenthood tends to be more extensive than intensive because of the sheer weight of numbers and demands.
3. One learns to live in a very real world and to deal early with the realities of life. Not much is a crisis!
4. The emphasis is on the group rather than the individual.
5. Group functioning calls for organization and leadership. This tends to put parents and/or siblings in very dominant roles.
6. Emphasis on qualities of behavior which are group essentials. Conformity is valued above self-expression. Cooperation, duty emphasized. Family functions as a group to do group chores.
7. Rules of conduct and procedure are a necessity.
8. Specialization of task, role and function among the children is necessary.
9. The greater the degree of such specialization, the greater the degree of interdependency that results.
10. Parents develop detached, objective attitudes toward child problems.
11. One comes to terms with life.
12. As a system, the large family seems not to perpetuate itself. (Bossard, p. 305)

Bossard concluded that when a family has over six children, it clearly has a "distinctive pattern of living" (p. 16) and becomes what he called in his book title *The Large Family System*.

In my documentary study, I used, as Bossard did, a questionnaire sent out to 2,000 large families all over the United States and Canada. My questionnaire, with minor alterations, duplicated his so that I could determine whether or not large adoptive families replicated the large family system as he defined it, in spite of the variables of being multicultural and not genetic in origin. As Bossard did, I used the first 100 responses returned from families that had six or more children. After adjusting for inflationary and societal changes that have occurred since 1956, I found that the picture of the large family and the large family system appears to have undergone little change. Bossard's characteristics are also characteristics of the large adoptive families in my study. Both of us went into detail, describing how these characteristics played out and how they were seen as both positive and negative through the eyes of both parents and children.

Obviously, more work needs to be done. I plan to do a longitudinal study. Much of this work will need to be qualitative, not quantitative in nature, perhaps much of it even in the context of oral history. Unfortunately, it appears that much of what is done from this point on in the documentation of large family history and systems may well need to be approached more from a historical than a current lifestyle perspective.

Further exploring the application of systems theory to the large adoptive family system also moves into the predictability of success and/or failure of children with certain personality types who enter into an existing large family system. We can look also at the impact of certain children or ages and number of children on the functioning of present family systems. For example, during the formation of many large adoptive families there is a prolonged period of disequilibrium. This happens when a family barely achieves, or doesn't quite achieve, a state of comparative family balance following one placement before another occurs. What are the effects of such chronic disequilibrium on family functioning and well-being? Perhaps, up to a certain point, you end up with parents and children who are more flexible and adaptable because of such extensive practice! At what point, however, does the stress of such a demand for adaptability cause dysfunction in both marriage and family relationships? How does a family realize when this is beginning to happen? Can such awareness help to prevent family crisis? Adopting sibling groups adds to the complexities. Now two competing systems, the adoptive family and the incoming sibling group, are both seeking some sort of balance. Again, can awareness of process help to avert crisis?

It has become imperative for us to explore some possible ways of preventing disruptive tragedies by the use of relevant and possible treatment tools such as those that are a part of family systems theory. In adoption, I am not sure that the complexities of the collisions of systems of birth parents, foster parents, unrelated sibling groups, and children coming into families at a variety of ages and stages, lend themselves well to the treatment tools that are normally used to produce change. Also, in regard to large families, "Arithmetic increase in the number of persons in the group is accompanied by a markedly increasing acceleration in the number of relationships within the group" (Bossard, 1956, p. 117).

Where, then, can intervention start? What, in fact, constitutes change? As Minuchin (1974) states,

> In all cultures, the family imprints its members with selfhood. The human experience of identity has two elements: a sense of belonging and a sense of being separate. Every member's sense of identity is influenced by his sense of belonging to a specific family. (p. 14)

Which family "imprints"? Birth? Adoptive? Both? All? Which family influences the "sense of identity"? To which does the child feel "a sense of belonging"? What can be done to assist such families in their adjustment and/or make their chance of success or failure more predictable?

Here, I believe, family systems theory plays a crucial, predictable, and influential role. If we know how family systems work and understand their quest for balance, we can educate families in the real issues of adoption that may well impact on this balance, and help them to make well-thought-out, educated decisions, after much soul searching, as to "how and how many" they might wish to adopt, and/or whether adoption would even be appropriate for their situation. If we understand changes in transactions or subsystems when major changes occur and a new balance must gradually be established, we can prepare families to recognize and meet these expectations. For example, a large family may well need to prepare itself for the reality that it may not have a child who truly attaches or bonds to their family. The collision of systems may be prolonged for years. Family balance may well involve giving a child a sense of family identity and belonging—a sense of stability in the consistency of relationships—but little more. This may well become an altered state of balance with which both family and child can find comfort—a realistic altering of expectations. In actuality, large families seem to have many of the characteristics that might make such an alteration of expectations quite possible.

For example, Bossard's (1956) findings show more detachment and less intensity in the parenting role in large families with the "emphasis on the group rather than the individual" (p. 141). For the child with bonding/attachment struggles who needs desperately to simply stabilize, the pressure is off. But what does this say to the placement of extremely disturbed and destructive children into these families? Perhaps predictability as a preventive tool might be very much in order. If there could be some knowledge of what to expect and potential problems to look for, then family systems theory, as set forth in Bossard's study and conclusions, could be of enormous help in the assessment of a family's chances of success and of how much disruption a particular placement might cause in an established large family system. Predictable properties that can and do influence a person's and a family's *present* and *future* functioning I believe to be applicable, necessary, and often crucial elements in the entire adoption process.

Conclusion

The unquestionable fact is that large adoptive families and the systems they function within often appear unusual by the standards of a society with a small family focus. It is also a certainty that many children who otherwise might have gone unplaced, or whose placements might not have lasted in a more traditional-sized family, have often thrived within the uniqueness of large adoptive family systems. Placement stability rates have been excellent. Although actual numbers of large adoptive families may be small, their impact on the future of the numbers of children to whose lives they have given stability is beyond measure. No wonder that their story needed to be told—from past and present perspectives, and to prepare for future challenges.

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Intercountry Adoption

12

Susan Soon-Keum Cox

For literally thousands of children throughout the world, intercountry adoption is the only viable possibility for them to have a permanent loving family. Whenever there is a disaster, whether from natural causes, armed conflict, or human atrocities, the predictable consequence is that children are the most vulnerable. Their survival, both immediate and long-term, is the most fragile.

Each displaced and orphaned child's situation must be evaluated in an expedient manner to determine the best *permanent* plan for his or her life. It is the natural order of things, and the fundamental right of every child, to live and grow up as part of a family. Intercountry adoption is the optimum alternative for many homeless children; however, it is not the universal response for all of them.

Every child should grow up with his/her birth family—and vigorous effort should take place to make that possible. Unfortunately, for many children, particularly children in developing countries, this is not reality. For them, the next priority should be to find a suitable adoptive family in the child's birth country. When that is not a viable option, and too often it is not, it is tragic for these children to spend their developing years languishing in institutions when there are families in other countries who would love and care for them as their own.

Intercountry adoption is an extremely sensitive and emotional issue for both the citizens of the sending countries and those in other often more affluent, countries who want to adopt these children. Acknowledging this sensitivity includes a commitment to the principle that intercountry adoption is a matter of privilege, not of right. Nations are responsible for the care and protection of their citizens, including homeless children who may potentially be adoptable.

It *must* be a priority to respect the dignity of the child's birth country as well as that of the child. Whenever a country supports intercountry adoption as a means for a child to have a family, it is surrendering a great deal. A nation's decision as a matter of policy to permit intercountry adoption of its homeless children is complex. The sending country has the right and the responsibility to define an adoption system it believes will protect the best interests of its children.

It is an indication of respect to the integrity and caring of the child's birth country not only to *invite* but to *expect* sending countries to participate and be active in developing and establishing societal programs themselves. The leadership of any country must feel ownership of the process if the process is to be truly effective.

Predictably, when a country first begins to allow its children to be adopted internationally, the system is bureaucratic, cumbersome, and slow. Deliberate and significant effort must be made to work constructively toward improving the system, rather than trying to circumvent it. Anything less is not only shortsighted, but puts at risk the long-term potential of helping greater numbers of displaced children.

Adoption agencies, facilitators, adoptive parents, and adoption advocates must understand the "bigger picture" and be diligent in honoring the process. They must be part of the solution, not contributors to the problem. In certain countries, including Honduras, Bolivia, Romania, Thailand, India, and others, contrary efforts have jeopardized and even sacrificed the possibilities for children who could be served in the future.

Modern History of Intercountry Adoption

The modern history of intercountry adoption began in the mid 1950s following the Korean War. Harry Holt, an Oregon lumberman, and his wife Bertha saw a documentary about children born in Korea to Korean mothers and American fathers. The children were referred to as "mixed blood," and their future as unacceptable in Korean society was a certainty.

In a culture that honors their ancestors through Confucian tradition, purity of lineage is highly regarded as a measure of one's worth. These children were born not only outside of marriage, but outside of even marginally acceptable circumstances. The mothers who gave birth to these children were shunned as well. In a country devastated by war there was rare opportunity for these children to survive, let alone flourish.

Disturbed by compelling pictures of children who were malnourished and ostracized, the Holts were determined to help. They began by sponsoring several children in an orphanage. Although they already had six biological children, in the fall of 1955 they decided to adopt eight orphaned children from Korea.

The Refugee Act of 1953 limited to two the number of children a family could adopt from overseas. The only exception was the separation of birth siblings. In May 1955, Senate Bill 2312 for the "relief of certain Korean War orphans" specifically allowed the Holts to adopt and bring eight children from Korea to the United States. The passage of the "Holt Bill" in July of 1955 made way not only for the Holts to adopt, but also established a process by which thousands of children from Korea, and later other countries, could be adopted by families in the U.S.

In 1961, the Immigration and Nationality Act allowed for permanent reference to the immigration of orphans adopted by Americans, and the limitation of two orphan visas was abolished in the late 1970s.

The media has had an important role in influencing intercountry adoption, beginning as early as the first adoptions from Korea. When Mr. Holt arrived in Oregon with eight newly adopted Korean children, radio, television, and newspapers around the country told the story of this ordinary couple who had just done something extraordinary.

People across the United States were touched by the plight of children in Korea and were motivated to adopt them. Within months, the Holts were helping families adopt Amerasian children from Korea, and the Holt Adoption Program—and intercountry adoption—were born.

A "Social Experiment"

This was not a concept that was universally embraced. Although American families had adopted children from Europe, these adoptions from Korea had the added complication of distinct racial differences between parents and children. Some critics considered it a crazy social experiment; others acknowledged that these were cute babies and delightful toddlers, but worried what would happen to them when they grew up. Who would give them jobs? Who would marry them?

In spite of the skeptics, hundreds of American families followed the Holts' example. Within a few years, thousands of Korean children with Asian faces who arrived in the U.S. with names like Kim or Lee became Jones and Smith. They lived in communities across the United States, became American citizens, and in every way became Americanized.

Families who were pioneers in this process were encouraged to "love these children as your own." They were also advised to help their adopted children learn the language, food, customs, and culture as quickly as possible. "Fitting in" American society was considered a necessary priority. Nearly all the children first adopted from Korea were Amerasian and often their appearance varied greatly from one another. Some children were light-skinned with blond hair and limited visible evidence of their Korean heritage. Children with black fathers appeared less Korean and more African American. Many children looked distinctly Korean.

Particularly during the 1950s, intercountry adoption from Korea was an answer to survival, both physical and social, for displaced Korean children. The greatest priority was to find adoptive

parents that could love a child not born to them as well as coming from another race and culture. The primary emphasis was to absorb these children into the culture of their new adoptive families as quickly and completely as possible.

There was widespread concern that for these adoptions to be considered successful, it was necessary to demonstrate that children from another country and culture could effectively assimilate into their new family and American society.

And it worked. Children adopted from Korea, then from Vietnam, and later from other Asian and Latin American countries, were convincing evidence of a child's ability to be transplanted successfully from one culture to another. These adopted children are considered to be more American by culture than defined by their birth heritage and physical appearance. Simply by osmosis, it is their primary nationality.

As intercountry adoption has evolved and matured, there is less fear and anxiety surrounding the necessity of proving its appropriateness. More attention and concern is focused on embracing the child's birth country and ethnicity as valued and important for the adopted child.

There is a uniqueness to being an international adoptee. Perhaps the most defining circumstance is that, for the most part, these are interracial adoptions with obvious racial differences between adoptees and their parents and other family members. The physical differences are often a source of public attention and scrutiny. Every adoptee born in another country and culture comes to his or her adoptive family with a previous history as an important part of who he or she is, even if it is a history he or she does not personally remember.

There are choices. An adoptive family may ignore, or make little effort to include, the cultural heritage of the adopted child as a part of its parenting. That decision does not necessarily indicate that the child is not accepted, loved, or cherished as its own son or daughter. However, when the adoptive family also accepts and honors the cultural identity of the child's birth heritage, it enriches not only the adoptee, but the entire family and extended family as well.

Why Families Adopt Children From Overseas

From its early history, a variety of factors have prompted families to adopt children from another country. Families in the U.S. were motivated to adopt children from Korea in the fifties, from Vietnam in the seventies, and Romania in the nineties, by unusual and compelling circumstances. War, armed conflict, sweeping changes in government, desperate physical conditions within the country, and media stories documenting these, amplified the despair of parentless children.

Families who might not have been considering adopting a child from overseas, or even considering adoption at all, were moved by these dramatic events, and responded by reaching out to these children. These adoptions were initiated by a powerful emotional response.

A number of families decide to adopt a child from overseas when other family members, friends, or co-workers adopt internationally. Observing the adoption process, and later the arrival of a child from another country, may revive previous interest in adoption, or stimulate the idea for the first time. For those who are unfamiliar with adoption, these personal experiences generate a thought process that is usually the beginning of any adoption experience.

Sometimes adoptive parents are drawn through strong personal interest to a particular country or culture. It may be from their own ethnicity, or the ethnicity of someone in their family or close friends. They may feel particularly connected to a specific country or culture because they have lived there themselves, or are familiar with the language and customs. It enhances the adoption experience and is mutually beneficial to both the child and family when families adopt a child from a country to which they already feel a strong personal attachment.

It is normal that adoptive parents consider the birth parents, primarily the birth mother, of their adopted child. It is natural that some parents feel a certain amount of anxiety that the birth mother might come back well into the future, change her mind, and want to retrieve the child who is now "theirs." Some adoptive parents fear the existence

of the birth mother and her possible intrusion into the life of the adoptee and adoptive family. These adoptive parents may seek intercountry adoption believing foreign adoption reduces the risks and provides assurances and a sense of security from the possibility of being "found" by the birth mother.

It is true that the possibility of an adoption being traced by birth mothers in another country is greatly reduced by barriers of geographic distance, resources, and language. However, the greatest separation and difference is cultural. Similar to U.S. adoptions that once were shrouded in whispers, shame, and secrecy, birth mothers overseas commonly relinquish their children for adoption in secret. Privacy allows them to melt back into society after the birth of the child. The unfortunate consequence is that seldom is any accurate information available, should the adoptee desire to initiate a search as an adult.

This commitment to secrecy also affects information regarding the child who is to be relinquished for adoption. Concern for protecting the confidentiality of the birth mother and concern that she might someday be identified without her consent, has the unintended and undesired effect that false identifying information is presented at the time of relinquishment. This information includes medical history, personal history, and other pertinent data that is critical knowledge for a family considering adopting, and possibly for the adoptee in the future.

This is changing slowly. A few international searches have been completed successfully by both adoptees and birth parents. These occurrences are rare, but will no doubt increase as they have in United States domestic adoptions. It is imperative to continue to advocate for truthful and open dialogue between birth mothers and social workers during the relinquishment and adoption process. The necessary commitment to educating and reassuring birthmothers, social workers, and others who are part of the adoption process should include a responsible tone of caution and not preclude the importance of understanding the diverse and profound cultural sensitivities these issues present.

To ensure a true and complete acceptance of these concerns overseas, receiving countries bear the burden of exhibiting prudent and patient attitudes and must provide guidance and reassurance to sending countries. Social changes evolve at what often appears to be a painfully slow and measureless pace. Experience dictates that the long-term results are significantly more effective if the learning curve is not hurried beyond the ability of those involved to truly understand and accept.

During the seventies, adoption practices in the United States became more open and responsive to the long-term interests and sensitivities of the complete adoption triad, including adoptees, birth and adoptive parents. These changes also affected the practice of intercountry adoption. Single-parent adoptions became acceptable to some sending countries, particularly Latin America and India. This allowed more parents to adopt, and, more importantly, more children to be adopted.

The seventies also marked the beginning of expanded private and independent adoptions. Agency adoptions had predominately guided how adoptions were facilitated prior to that time. The usual differences between private, independent adoptions domestically in the United States essentially illustrate parallel differences in intercountry adoption practices as well.

Complex Legal Processes

Any adoption facilitated in the United States must comply with federal U.S. laws and appropriate state laws. Foreign adoption includes the added complications affected by differences in language, customs, government, laws, and regulations. Additionally, intercountry adoption requires the approval of the United States Immigration and Naturalization Service (INS), which necessitates another layer of bureaucracy and paperwork. This includes verifying that a child to be adopted meets the guidelines established for intercountry adoption as defined by the INS.

The Immigration and Naturalization Service defines "orphan" as:

> an alien child who is an orphan because of the death of both parents, or because of abandonment or desertion by, separation or loss from, both parents, or who has only one parent due to the death or disappearance of,

abandonment, or desertion by, or separation or loss from the other parent and the remaining parent is incapable of providing care for such orphan, and has in writing irrevocably released him for immigration and adoption.

Only children meeting this definition of "orphan" can be issued a visa to immigrate to the United States. It is imperative for prospective adoptive parents to work with an adoption agency or facilitator knowledgeable in intercountry adoption requirements to ensure the child they hope to adopt meets the Immigration and Naturalization definition of adoptable orphan. This assures a child adopted overseas will be allowed to enter the United States. International adoptions are further regulated by the laws and procedures of the sending country. These laws and procedures vary widely.

An international effort to bring consistency to intercountry adoption is being attempted by The Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption. The Hague Convention is a multilateral treaty that will cover all adoptions between countries that become party to it, whether those adoptions are parent-initiated or are arranged by adoption agencies or by private/independent providers of adoption-related services. The treaty sets certain minimum norms and procedures that are to be followed to protect the children, birth parents, and adoptive parents. The Convention also regulates prior approval for children to immigrate into their new countries.

The U. S. Department of State has identified the following advantages offered by the Convention: It constitutes the first formal international "stamp of approval" for intercountry adoption. It will counteract any possible effects of ambiguous language in the United Nations Convention on the Rights of the Child. The Hague Convention explicitly recognizes that the child, "for the full and harmonious development of its personality," should grow up in a family environment, thereby placing intercountry adoption ahead of foster or institutional care in the child's country of origin. By providing that national "Central Authorities" be established in every party country, the Convention ensures that there is a single authoritative source of information about the law and procedures for intercountry adoption (Freivalds, 1993).

Who Is An Orphan?

It has long been considered antiquated to use the term "orphan" to describe children in the United States not living with birth parents, such as U.S. children in foster care, or other placement. However, "orphan" is still commonly used to frame or define a child living in similar circumstances in other countries. These children, especially those in developing nations, generally live in orphanages or institutions that may appear to make this definition more illustrative of the child's reality. The media generally represents foreign children in stories and news accounts as "orphans," although reading beyond the headline often reveals a child who is displaced, but obviously not an orphan.

It is the regular and accepted use of this and other terms applied to children in developing and sending countries that also continues to perpetuate the concept that families who adopt these children are "saving them." That view can be followed by the idea that these adoptive families are "noble," "good," or "extraordinary." At a time when overall immigration policies are becoming increasingly controversial, the other extreme includes, "Why are you bringing those children here?" Neither of these positions reflect positively for adoptive children.

Children do not want to be told, much less to feel, that they were "saved." That translates into "pitiful and helpless." While pitiful and helpless might very well describe a child's life prior to adoption, it also brings with it feelings that defy human dignity and positive self-worth. It also reflects an attitude that can be perceived, however unintended, as demeaning to a sending nation.

Poor and developing countries struggle and are often unable to bear the responsibility of caring for the increasing numbers of children who live without benefit of family or other caregivers. These children live marginal existences in undersupported orphanages and institutions. Every day, thousands of these children die and are a loss to our common humanity. Under these conditions, the children who do make it are survivors. As a poor country acknowledges very real limitations in caring for its homeless children, this is understandably accompanied by strong reticence to permit intercountry

adoption. Although this may seem a confusing contradiction, it reflects the natural ambivalence of both birth parents and sending countries—wanting the best for their children, but not wanting to let them go.

Scope of Intercountry Adoption in the United States

Four decades of intercountry adoption to the United States literally translates into more than 200,000 children in this country who are international adoptees. More than 50,000 have been adopted from Korea. Beyond the adoptees themselves, the numbers expand to include adoptive parents, siblings, grandparents, aunts, uncles, cousins, widely extended families and normal close attachments through friends, neighbors, church, and school.

It can be generally assumed that the U.S. public is aware of intercountry adoption, even if only from reading an article or seeing a news report. Considering how many people have at least some personal experience with international adoption, this would be expected. However, in spite of the scope of intercountry adoption in the U.S., outside of the immediate adoptive circle, there is minimal understanding of more than superficial issues. For the most part, intercountry adoption is accepted and acknowledged as beneficial for both the child and family. The volume of awkward and sometimes intrusive inquiries that international adoptees and their families are often required to endure gives evidence that a deeper public sensitivity has not developed. Another perspective is that these children and families are considered the same as any other, and no special consideration is needed or required.

International adoptees and their families do see themselves as any other family, with all the usual complexities. The issues that typically delineate distinctions between birth and adoptive families are more obvious for intercountry adoption, since the physical differences are so obvious and public. As a normal part of child development, all adopted children experience the realization that they are not their parents' biological child. It is not unusual for them to wonder about their birth parents, especially how they looked.

International adoptees are generally a different race than their parents and do not resemble them physically. These obvious physical differences generate intense speculation and curiosity from a variety of sources, including other family members, complete strangers, and casual observers. These dissimilarities of race and culture are likely what most defines intercountry adoption.

The differences are real. No one understands that with greater clarity than the adoptive family, and ultimately, the adoptee. Early in the adoption process, prospective adoptive parents must explore their feelings about these issues with their extended family, social worker, or adoption facilitator. Most importantly, they must explore and come to peace with these issues deep within themselves.

Beginning with the first social introduction outside of home as toddlers, throughout the lifetime of international adoptees, they may be questioned about their adoption because of how they look. Adoptive parents give voice to the necessary explanations until the children are old enough to take on the responsibility to articulate for themselves. It is beneficial when adoptive families consider this challenge thoughtfully. The answers provided by parents will later be echoed by the adoptees when they can speak on their own behalf. Parents and other significant adults can guide the adoptee in learning the appropriate boundaries of what should be shared about their adoption experience. *In respecting the normal relationships of communication, adoptees should also learn to respect and honor their own right to privacy.* Their adoption experience belongs to them and they should share it when it feels appropriate to them. Whenever questions are asked, it is an opportunity for adoptive families to encourage the use of appropriate adoption language.

Family relationships are defined by emotions, feelings, characteristics, and personalities of individual family members. What is felt, more than what is reflected on individual faces, establishes and binds families together. It is the true essence of adoption. Those feelings evolve from being with one another and creating shared history. This commitment is understood by adoptive families, but

seems mysterious beyond the extended family. Strangers in supermarkets inquire why the child "looks different," or "Couldn't you have children of your own?" and remark, "How lucky that little child is."

At some time in an adoptee's development, he or she finds this public curiosity confusing. Sometimes it is annoying and intrusive. Adoptees have various tolerance levels of these situations determined by their own personalities.

How the Professional Community Can Help

As increasing numbers of children are adopted from other countries, educators, physicians, public policy leaders, clergy, and others should consider the profile of these children and families. These families, who are routinely called on to validate that they are a "real" family, would benefit from the combined support base of a fundamental understanding of international adoption issues.

The challenge is to achieve a competent level of understanding to ensure sensitivity to important and relevant concerns without overcompensating. It's a critical and necessary objective for adoptive parents to reach a comfortable balance between heritage and ethnicity for their adopted child. Each child is individual and will react in a manner that is consistent with his or her personality. Adopted children also respond differently to adoption issues at various times as part of normal child development.

The non-adopted person is surrounded by genetic heritage and has easy access to family history. In families formed biologically, answers abound and are absorbed before the need for a question arises. Feelings of belonging and relatedness are taken for granted as they develop gradually and become a part of the person's identity.

Shared ancestry, family resemblances, and, in some cases, cultural heritage are denied the adopted person, who grows up separated from blood relations. As the adopted person matures, the need for information about his birth family may grow. Both external life events and internal processes may trigger the desire for additional knowledge or bring to the surface the need to know one's roots (Demuth, 1991).

What is important are efforts adoptive parents pursue to demonstrate to the adoptee, and other family members, their willingness to absorb the child's ethnicity into the family. These attempts to include and celebrate a child's birth culture should include the entire family, and be in harmony with other family activities. If limited to the adoptee, they underscore differences, rather than becoming opportunities to share what the child brings to the family. Extreme efforts to provide cultural sensitivity and awareness to adoptees may meet with resistance, since it glaringly articulates that the adoptee is unique from other family members.

Resources Available

As intercountry adoption has evolved, so have resources to help internationally adoptive families. These resources help educate and better prepare parents to meet the challenges and opportunities of parenting a child from another country.

A critical resource, before and after adoptive placement, is parent support groups. These groups are an important source of information, as well as support and encouragement, during the sometimes long and difficult adoption process. Parent groups can alert those in the process of adopting to issues of irregularity and concern. The network of information-gathering that is accumulated and shared by adoptive families through support groups is amazingly swift and sophisticated. These groups share the commonality of wanting to protect and secure the adoption process and the children who are to be adopted. Anyone interested in adopting a child should connect with a parent group. Joining with other parents and adoptive families is powerful support. The relationships can be richly rewarding long after the adoption is complete.

As adoption has expanded, so has an adoption-related consumer industry. There is a growing inventory of books, magazines, newsletters, and videos available. Some of these attempt to address the specific issues regarding intercountry adoption. There are excellent books about more general adoption issues that are appropriate for any adopted child.

It's important not to assume that all adoption literature is accurate, sensitively written, or helpful. Rather, it is a very personal choice for each adoptive parent to determine his/her own informed philosophy of adoption. Not everyone defined as an "adoption expert" has either the experience or the perspective to which adoptive parents want their child exposed. Before reading or giving a book to their children, parents should read it first to assure themselves that it reflects the adoptive perspective they are comfortable sharing with their child. There are many well-established and respected books and articles that stand the test of time and continue to be relevant to today's adoption issues.

As more families travel to the children's birth countries to bring their children home, this experience is one of the most significant in providing ongoing resources to these children. By anticipating questions adoptees will ask in the future as they become adolescents and adults, families can gather information and pictures specifically about the children and their early beginnings. Cultural and ethnic traditions experienced or learned by adoptive parents while visiting the birth country will be treasured by the families and especially by the adoptees.

Adoptive families who pursue relationships and friendships with local ethnic populations in their communities help the adoptee experience other children and adults who look similar to them. The clear message to both the child and ethnic community that is the family is comfortable with and values the ethnicity of the child.

Across the United States, there are increasing numbers of culture and heritage camps for children adopted internationally. There are a variety of camps to choose from, including day camps for elementary age children, to week-long camps for adolescents. Particularly for adoptees who live in communities where they have little opportunity to be with other adoptees or children of color, camps are a valuable learning experience.

Extending of the concept of heritage and culture camps are tours for adoptees and their families to visit their child's birth countries. These trips back with other adoptees are often considered a positive but dramatic life experience for young adult adoptees. When an internationally adopted child's experience includes his or her heritage and culture in an ongoing manner, adoption books, camps, tours, and adoptee groups are simply a normal progression of the adoption experience.

Conclusion

If you are adopted, you are an adopted person forever. This includes international adoptees. The issues of adoption, of race and ethnicity, change with individual life experiences. International adoptees grow up. They get married, become parents, and some have already become grandparents. International adoptees are living ordinary lives in communities throughout the U.S. Their individual experiences are as rich and varied as the individual families that adopted them. Collectively, they represent the enormous capacity for human resilience of which children are capable. Families are the most enduring and important of relationships. Intercountry adoption transcends the boundaries of race, nationality, and culture. It gives a child a family that is as "real" as any family. International families illustrate what is possible when people are willing to recognize and honor differences while discovering and making commitments to the common need for "family" that exists in each of us.

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Asian Cultural Issues in Adoption

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Asian cultures have great diversity among them but the area of greatest similarity is in the importance of family—the honor of the family. The structure of the family is maintained by specific roles for the father and mother and the duties of each are often held in place by social and cultural pressures emanating from a homogeneous cultural environment. Thus families operate in a similar manner and the roles of children and youth are defined both by religious and cultural teachings and the forces of the cultural milieu in which these families flourish.

Relationships are therefore not as fluid nor deeply personally directed. They are more the by-product of the form and function of the society. Although the youth of the Asian countries see themselves as self-directed in their choice of mates, for example, in reality these choices are much less free since the individuals already live within the context of a group conscious society that does not allow for individualism such as exists in the United States.

The preservation of the family—its "good" name are of prime importance. Children represent the family's ability to carry this forward. Males are thus more important than females and the specific reason for having a male heir might have some subtle differences within each of the Asian cultures.

Very little is written in English with regard to adoption issues in Asian cultures. Perhaps not much more is available even in Asian languages. From this dearth of written material this article will present personal observations of the author and will be focused upon attitudes and practices in the Japanese culture.

Adoption is most familiar to Japanese in its adult form. When a family of means has no sons, it is customary for the parents to seek a husband for their eldest daughter who will agree to the marriage and agree to change his name to that of his wife's family. He is thus adopted into this family by marriage and is entitled to inherit the family's property, business and any other holdings. In Japan only the eldest son is entitled to the family inheritance. In families where there are many sons, the younger males may be available for adoption.

Infant adoption is therefore not necessary to carry on the family name. Infant adoption occurs in families where there is infertility. The woman's barrenness is a problem both because of family name issues but also because the woman's role in the family is centered on caring for and nurturing the children. A childless couple creates a certain imbalance since the social roles of men and women are clearly structured and defined. A man's social life often does not include his wife. There are family functions and social events for all to attend as a family but it is not customary for a husband and wife to be out alone as a couple after marriage.

Historically children have been given away in adoption often as repayment of debt or obligation. One of the younger sons in a family of many males might be given away. Females might be given away as a young child, not necessarily an infant, particularly if such child were beautiful or talented.

In the past, when marriages were arranged, the personal relationship between a husband and wife was not important. Both husband and wife had defined roles and the marriage was successful when these roles were accepted and fulfilled. Families were caring and often selected mates that were

suitable for their offspring. Love was not a primary consideration for the couple and the development of a personal, intimate relationship was not fostered nor necessarily desired.

Pregnancies that occur outside of marriage caused the greatest shame and embarrassment when the social system could not find an honorable way to accept them. In wealthy families a male child born outside the legal family could still have a place in the family if there were no other sons. In that event, the son could be brought into the home and be reared as a legitimate son. His mother would be required to relinquish rights to him. If this child were female the mother might be forced to abandon her. If there were already sons in the family the mother might be allowed to keep her son if the father were financially capable of supporting a second household.

Japanese immigrants brought these same values with them when they arrived early in the 20th century. Adult adoptions and giving children away for reasons and debt and obligation occurred among the early settlers and their families. The American-born children of these Japanese immigrants quickly rebelled at having their marriages arranged. The young couples adopted the Western style of selecting their mates and when they were unable to produce offspring, they began to adopt children through agencies and/or through international placement agencies. These children had to be primarily Asian and only rarely were children of mixed racial heritage adopted.

Third and fourth generation Japanese-Americans are no longer marrying within the race. Well over 50 percent are marrying outside the race. Consequently children of mixed racial backgrounds are acceptable for adoption. However, as a group, special needs children and refugee children are not adopted. Foster parenting of children who are not related is also uncommon. Transracial adoption of a child who does not look Asian is also not acceptable. Japanese-Americans still have difficulty talking about their feelings and sharing these feelings with others. Many who have adopted children have not dealt with their own issues of infertility, of their own relationship issues and would not be able to deal with the issues of adoption.

The Japanese-American community as a whole are not offended by non-Asians adopting Asian children. The idea of accepting a child that is not one's own and to love and nurture that child out of a need for connectedness and fulfillment is still somewhat foreign to Asian Americans. Perhaps those with a strong Christian background can relate but generally the desire for offspring comes from the cultural view of having a child to carry on the family name—to have children to balance the family's role and function.

The Latino Child in Transracial Adoptions

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Dee Dee Mascareñas, M.A., M.F.C.T.

According to the 1990 census, by the year 2000 the Latino population will comprise the largest ethnic group in the United States.

What should first be noted when discussing work with an individual originating from a Spanish-speaking country, or a descendant of such an individual, is that there is no one unifying name that comprehensively or adequately describes the variations of cultures encompassed by the term "Spanish-speaking." Some would like to be called Hispanic, others Latinos, others Chicanos, and still others simply define themselves based on their country of origin (i.e. Peru, Argentina, Brazil, Chile, etc.) It is therefore important to ask the individual or family what their preference is and the reasons for that preference, as the reason has significance as well.

For the purpose of this paper, I will refer to this population as "Latinos." It would be quite difficult to enumerate the multiple concerns that need to be taken into consideration and addressed when working with a Latino. If they are second, third or fourth generation, etc., they will have moved farther along in their bicultration process, farther than a newly immigrated Latino. While similar struggles exist for both these groups, the newly immigrated Latino finds his journey more intense as a result of the immediacy of his needs and concerns.

Therefore, I will limit this paper to focusing on the needs of the newly immigrated child. Specifically, the child (age 2-18) adopted from another country by a family of similar origin or as a part of a transracial adoption; or, the child who is a part of a family, newly immigrated to this country, who for whatever reason involuntarily lost or voluntarily relinquished their child for adoption.

Ego Development, Ethnic/Racial Identity Development and Racism

Ethnicity gives one a sense of connectedness, a sense of roots and integrity, a foundation from which to develop in many areas but most specifically in the area of positive self-esteem. It also connects people who share a common ancestry in a number of significant ways.

There are many who fear that the current trend towards multiculturalism (the celebration of differences) disconnects the individual from the larger community or "mainstream society." The opposite is true, for as an individual is able to develop a positive and healthy sense of self, they are more fully able to connect with others from a position of acceptance rather than from a position of rejection or as a victim.

As we become aware of traits or characteristics within ourselves that are unacceptable to us, we begin to reject the self. If we see those unacceptable traits in others, regardless of gender, race, religion, etc., we will also find them unacceptable. The unconscious is powerful and *will not* discern that it must *only* reject unacceptable traits in the self and not in others.

What can also happen along this continuum of self-acceptance and other acceptance is a process known as "splitting." This is a common process in the development of all children, but most significant in the development of adopted children. The adopted child unconsciously "splits" the adoptive parents and the biological parents and sees one as *all good* and the other as *all bad*. Therefore, any connection they have with the biological parents, be it physical or emotional, is sometimes seen as "all bad" or "all good." If the biological parents are

perceived as "bad" as a result of the abandonment issues it stimulates in the child, the child is unable to integrate *all* aspects of the self (negative and positive) in a healthy manner in order to develop self-acceptance and healthy self-esteem, which subsequently hinders their acceptance of others as noted above.

It is said that ethnicity "fulfills a deep psychological need for identity and historical continuity" (Giordano, 1982). In his study of the development of identity in adolescents Erik Erikson strongly believes that there is a direct positive correlation between the developed identity as it was linked to the past and the future. For Erikson, the establishment of a personal independent identity is the most important task for the adolescent. What the adolescent does in this stage is "refight many of the battles of earlier years" (Erikson, 1963 p. 261). It is a process of integrating the past, the present and the future and if that past or present have been filled with trauma it will be difficult to create a positive and meaningful future. The issues of greatest significance at this stage become that of "sameness" and/or "differentness": sameness and differentness within the self, within one's family and in the world (with one's peers). It is therefore easy to see how, based on Erikson's model, identity development for a multi-racial child or a child in a transracial home would produce an even greater struggle than for the average adolescent.

"The adolescent adoptee is the child now struggling to form a mature identity, a task he or she finds difficult because there is no way of integrating the past with the present." (B. J. Lifton, p. 43). There are common struggles that all adolescents have, but the adoptee's issues compounds this already difficult developmental stage. "…it is hard to know where you are going when you don't know where you came from — and hard to become an autonomous person when your parents and society control the basic facts of your heritage." (B. J. Lifton, p. 45).

The adoptee must therefore at this stage come to terms with the real loss he/she had — the loss of their connection with their birth family. H. J. Sants believes that the adoptee suffers from "genealogical bewilderment" or "adoption stress." Most people take for granted the existence of others in their life with whom they share physical characteristics. "As a matter of fact persons outside ourselves are essential for the development of our complete body image. The most important persons in this respect are our real parents and other members of our family. Knowledge of and definite relationship to his genealogy is therefore necessary for a child to build up his complete body image and world picture. It is an inalienable and entitled right of every person. There is an urge, a call in everybody to follow and fulfill the tradition of his family, race, nation, and the religious community into which he was born. The loss of this tradition is a deprivation which may result in the stunting of emotional development." (B. J. Lifton, quoting British psychologist, E. Wellisch, p. 48).

As the child struggles during this stage of his development so does the parent. When they view every unacceptable act the child exhibits, parents are often hurt, bewildered, and unsure of their own parenting skills as well as of the welfare of their child's future, as they stumble around trying to define themselves. It is also an option for the adoptive parent, that most parents do not possess, to disown any responsibility for the adolescent's struggles and subsequent behaviors, because after all this is not really their biological child…. "One psychiatrist, himself an adoptive father, expressed it like this: 'when your kid is acting up, when he's demonstrating all of his least appealing traits, you tend to be a lot more tolerant and forgiving if you can recognize those traits as your own, if you can grin and think — just like his old man. Hell! How can I blame him if he got it from me? But when you're not the old man, and the faults are alien and unrecognizable, you're going to be a lot tougher. You're going to wonder — where did the little bastard pick that up?'" (B. J. Lifton, p. 51).

The mental health community has recognized the impact of the lack of identity development to the degree that this is a major contributing factor in the formation of the Borderline Personality Disorder and Identity Disorder (DSM IV).

It is therefore imperative that a parent take an active role in helping their child to make this transition with awareness, patience and nurturance. If this is not done, it will most certainly contribute to the development of a negative sense of self, individually, ethnically and racially. Many therapists believe that once prejudices have formed, if noth-

ing is done to extinguish them, they become more rooted over time. This is true of both negative or positive beliefs. If a parent is unaware of this process of identity development and/or the existence of racism, this too can have a negative impact on the development and future of the child.

As described earlier, the process defined as "splitting" also becomes an issue as it relates to race and ethnicity. Whereby if the child rejects the part of them which is different not only from "mainstream society," but more significantly the part of them which differs from their adoptive parents, they may begin to see their birth parents not only unacceptable as individuals, but also ethnically or racially. This "sets them up" to reject the ethnic/racial part of themselves that is a part of their biological family. Consequently, the child, already fearful of abandonment, will most certainly move in the direction of pleasing the adoptive parent by assimilating the values, ideas, beliefs and even culture and race of the adoptive parent. Regardless of the impossibility of the task, the child will do their utmost to be accepted. The more "outwardly" different the child is from the adoptive parent the more difficult the task. The further entrenched that child was in their ethnicity and culture, based on the age of their adoption, the more difficult the task as well. Patricia G. Ramsey, in her research on how children think about ethnic differences (Phinney, Rotherman, p. 71) noted the following: "Interestingly, children feel that their identity can change with the acquisition of cultural traditions and artifacts."

In Ponterotto, Pederson (1993, p. 32 & 33), they note that parental influence is "without question, the greatest influence on young children's attitude development." They further go on to define a number of behaviors that contribute to the development of negative racial prejudice in children, specifically: "(1) not discussing racial issues in the home, (2) not having a culturally diverse group of friends visit the house with regularity, (3) not confronting prejudicial remarks when heard in the company of the children … (4) allowing children to remain in segregated environments … or making attempts to compensate for such isolation … and (5) not pointing out the positive aspects and strengths of diverse cultures, including their own." Accordingly, if a parent were to knowingly or unconsciously engage in the above-described behaviors, the impact on the child would be detrimental. With regards to a child of color, this would most certainly contribute to the development of, or add to the process of internalized racism.

Often White America takes for granted that all other Americans hold, or should hold, the same values as they and subsequently judge them accordingly. This contributes to misunderstanding, preconceptions and prejudice. Therefore in the case of the transracial adoption it would be therefore important that the parents assess their own awareness of racism in America as well as within themselves and in their family (nuclear and extended). Whether covert or overt they may be intentionally or unintentionally contributing to racism.

"Racism brutalizes and dehumanizes both its object and those who articulate it" (Pederson, 1992 p. 6). The dominant culture, as an inherent part of racism, possesses a number of tangible and intangible benefits, such as social privilege, political power, higher levels of economic development and status, and as a result, higher levels of self-esteem and positive identity development. (See McIntosh, 1988).

From an article entitled "What Did You Say You Were? Am I a Racist? in *Confronting Diversity Issues on Campus* the author includes the chart, Myths and Realities of Racism which is reproduced on the following page.

We will revisit the subject of what parents of a child of color can do to help address the area of racism and healthy self-esteem and identity development later in this paper.

The Latino Culture

In order to fully understand the needs of a Latino child, it is important to understand the Latino culture. What motivates and defines the Latino in terms of ancestry, language, codes of behavior, values, time orientation, family makeup, gender roles, sexuality, work ethic, education, spirituality, etc. As noted previously, it would be difficult to define the Latino adequately as the Latino originates from a number of different Spanish-speaking countries, each with their own cultural "flavor." However, for purposes of this dis-

Myths and Realities of Racism

Myths	Realities
1. There are three distinct physical races.	1. Racial differences are social, economic, cultural & political.
2. Not everyone has a culture that matters.	2. Everyone has a complex culture that matters.
3. Racism is personal and happens.	3. Racism is personal, institutional, & cultural.
4. Affirmative action is reverse racism.	4. Affirmative action seeks to reduce racism.
5. Racism is an on-off phenomenon.	5. Racism operates on a continuum from overt to covert.
6. Racism must be conscious and intentional.	6. Racism ranges from conscious to unconscious.
7. Racism must be mean-spirited.	7. Racism ranges from mean-spirited to well-intentioned.
8. What happens to people of color is unimportant.	8. Our racial communities are interdependent.
9. Racism exists when European Americans say so.	9. Racism can be identified by the victim, perpetrator or observer.
10. "I couldn't possibly be racist because I have friends in other races."	10. You can be a racist and have friends in other races.
11. Racism is inevitable.	11. Racism is not inevitable.

cussion there are some similarities that hold true for Latinos as a whole and will be defined as follows.

Ancestry

Latinos are a mixture of Spanish ancestry combined with the indigenous population of the lands that they conquered ("Mestizos"). For instance, Mexicans are a mixture of Spanish and Mayan and Spanish and Aztec. In Central America it is predominantly Spanish and Mayan. Still in other countries the Spaniards massacred the indigenous peoples of the land and either intermarried or married with African slaves that they had brought with them. This is the case in Cuba, Puerto Rico and parts of the Caribbean. In South America the mixture is that of Spanish and Italian with the indigenous peoples. In some parts you may also find a Portuguese influence. There is a strong connection with Spain for many Latinos and for others there is a rejection of that connection and a deep longing for that which they lost in the conquest of their indigenous ancestors. No matter what the mixture may be, the rituals, spirituality and beliefs of the "native" still influence much of the modern day characteristics of the Latino.

Language

The language of most Latinos is primarily Spanish; however, each country has developed a different dialect or form of Spanish. Often times these differences, small as they may be, are even a barrier

to Spanish-speaking people themselves, depending on their country of origin. In some South American countries Spanish and Portuguese coexist.

Time Orientation

Latinos tend to be oriented first to the present, secondly, the past and thirdly, the future. The present is all there is, it is all that is within one's power to enjoy, to take part in or to develop. The past is that which gives one a sense of roots and connectedness to the generations before them. The future is "in God's hands" which is strongly connected to the spiritual belief that man is subject to the power of God and Nature. A common response to questions is "Si Dios lo Quiere", "If God wills it so."

Gender Roles

The Latino family tends to be patriarchal in nature. That is, the father is the head of the household, and the mother is subject to his desires, needs or concerns. His desire is to care for, protect, and provide for his family to the best of his ability, with respect, love and caring, for this is "Macho." ("Machismo" is a term that has been much maligned over the years in this country, however, originally it had a positive connotation). The wife is to assist her husband in these tasks to the best of her ability, using the skills available to her or that she develops. Therefore, gender roles are well defined and to some degree rigid for the Latino. This definition which may be considered "rigid" by white American cultural values, gives the Latino a strong foundation that helps create a sense of security and stability for family life.

The Family

The extended family is what defines the Latino as an individual, for in the Latino culture one is not alone, one is part of a whole, one is part of the "family." The family includes not only the nuclear component of what is thought of as "family" in the Euro-western sense, but also includes grandparents, aunts/uncles, cousins (first, second, third, etc.) Godparents, and even past generations (their ancestors). Still even more expansive, the Latino family often includes lifelong friends (of any ethnicity). As noted above, the family is more important than the individual, and conversely, the parental role is more important than the marital dyad. It is within this framework that includes a loose definition of family, a definition of inclusion, that there is no room for competition, the focus is towards cooperation and cohesiveness. This is done in order to define life and to contribute to and promote the family as a part of society as a whole.

The Work Ethic and Education

Self-esteem and integrity for the Latino is defined by "who" you are not what you do. "How" you do something not what you look like or where you do it. There is a striving for doing your work to the very best of your ability, regardless of whether your work is one which includes manual labor or one that is more intellectual in nature. Whatever you do to enhance that ideal, to develop your sense of integrity in doing the task as hand is acceptable; be that enhancing your education, physical mobility, expanding work responsibilities to include several jobs, all this is seen as valuable. Here again, the very strong spiritual component that comes from the indigenous roots of the Latino can be seen, in that the "essence" of the person is what is valuable and must be nurtured, rather than what is "non-essential," what is material, what is outside the self.

Spirituality

Spirituality in the Latino culture includes not only established religion, but also the development of the spiritual core or essence of an individual. There is then a combination of organized religion with indigenous beliefs that include a connection to that which is "natural," seeing the world symbolically, and understanding the need to nurture and develop balance within all parts of the self, balance with nature, and balance with all men. For many years, the dominant religion in most Spanish-speaking countries has been Catholicism, yet in recent years there has also been a strong influence from the Protestants as well, and they bring with them the component of education and personal responsibility.

Language: A Bridge or a Barrier

The U.S. is currently the fifth largest Spanish-speaking country in the world, and yet there is a bias in this county to only speak English and to value it as a language more important than others. In Europe, where people speak a number of different languages as a matter of everyday life, this concept is not understood. Regrettably, in this country, individuals who possess the ability to speak in two languages often struggle with the tendency to see themselves as less valuable if their strongest language is not English. Yet many believe that an individual who is fluent in two languages is worth two people, that they are in fact more astute, flexible and open to change and new ideas.

There was a time in America when the school system believed that children who could not speak English, especially in the case of Latinos, were less intelligent and slow to learn, and consequently they were placed in classes with "mentally challenged children." As a result of this injustice, the civil rights-based Chicano Movement of the '60s helped to bring this issue to the attention of American citizens in general and the school districts in particular. What came out of this struggle was the birth of "bilingual education." This was created to ensure that the child was learning the concepts that they needed to learn at their grade level in their own language, while simultaneously learning to master English. There are many camps of thought as to the validity of such an educational process, but nonetheless, it still exists in many schools today as a way to address this area of concern.

Other Considerations

Returning to the concerns of the newly immigrated child, it would be important for a number of variables to be considered with regard to placement and treatment. For instance, what country is this child from? Did the child experience war, death of a significant family member or abandonment as a result of that war? Was the child left in their country while their parents immigrated with the hopes of creating a better life for their family, while at the same time creating feelings of rejection, abandonment and neglect in the child who is left behind, waiting for them to find "success"? Is the child bilingual? What type of environment was the child exposed to, i.e. rural, urban, lower, middle or upper class? Was this an only child? What are the numerous losses this child must contend with as they are expected to simultaneously adjust to a new country, a new family, a new culture, a new language, and in some cases new races of people, which may or may not include their adoptive families. What are the fears and expectations this child has of this new country, as well as of their new family? What preconceptions already exist in the mind of the child about Americans, or about different racial or ethnic groups?

Recommendations

In her work on transethnically adopted Mexican-Americans, Dr. Estela Andujo (Andujo, 1988) provides empirical data and valuable recommendations. She believes that "ethnic identity appears to have been more of a problem for the transethnic adoptees than for the same ethnic adoptees, and supports the belief that ethnic similarity of adoptive parents and children is a factor that is relevant in adoption practice and policy." Dr. Andujo proposes that the placement of Latino children, in both policy and practice, needs to take into consideration the following: "(1) Permanent care in an adoptive home is preferable to long-term foster care, (2) Emphasis on ethnic identity is an essential starting point for the development of an ethnic sensitive home study, (3) Parents who adopt trans-ethnically should demonstrate a willingness to accept ethnic and cultural differences between themselves and their child, (4) Families who adopt children of different ethnic backgrounds than their own must be helped to recognize that the ethnic and cultural heritage of the child is an essential part of their psychosocial sense of self, (5) Agencies need to help families use the ethnic and cultural resources of the minority community to explore the realities of racism, (6) Parents need to be willing and able to acknowledge and deal with racism and cultural prejudice, and (9) Parents need to be willing and committed to imparting a sense of ethnic identification to their children by sustaining contact with members of the child's ethnic milieu."

The Policy Statement of the North American Council on Adoptable Children affirms a number of guiding principles that they believe hold priority with regard to children in need of a home. The principles that speak to the issue of transracial adoption are as follows: "… (5) If a relative is not available, or if placement with available relatives is not in the child's best interest, agencies should next endeavor to make a placement with an appropriate adoptable family of the same racial or ethnic background. Same race or ethnic placement fosters appreciation for cultural heritage and facilitates identification with adoptive parents. (9) When transracial or multi-ethnic placements are made, full appreciation and consideration should be given to the child's need for close identification and interaction with his/her culture of origin. Cross-racial and cross-cultural family assessment tools should be used when considering transracial and adoptive placements, and (10) Families who adopt transracially should receive ongoing support services to ensure that children of color have an opportunity to develop a complete understanding of their racial and cultural identity."

Given the many areas of concern addressed in this paper, it is clear that transracial adoptions create a particular set of distinct problems. One must ask if it is truly necessary, and in the best interest of the child to provide them with such a home — a home that inherently creates more issues for the adopted child to have to resolve, with or without support and guidance.

There are certain circumstances where transracial adoptions are necessary. However, it would be important, and this author believes, in the best interest of the child in *all* areas of their development, to provide them with a family that is most similar to themselves, racially, ethnically and culturally.

A transracially adopted child, much like the biracial child, needs to have healthy and intact coping skills to deal with a racist world. Some parents may think they are crippling the child by telling them the truth, that racism exists, and that one day they may be rejected or viewed as "less than" simply because of their racial or ethnic heritage. This is not the case, in fact, it is a loving parent who communicates with their child openly and honestly and provides them with information, support and healthy ways in which to combat the negativism that is inherent in racism.

In their paper on Transracial Adoptive Parenting: A Black/White Community Issue (1993) Leora Neal and Al Stumph share the following insight: "It is important that transracial adoptive parents *not* berate themselves for what are essentially society's ills. However, they should acknowledge that racism is a bitter fact of life and try to help their children to function in spite of it, while working to break down such barriers. It must also be recognized by both parents and children that every ethnic group has a cultural history that is worthy of knowing about and that to deny the worth of one's ethnic background and to not be proud of that background is to ultimately deny oneself."

I will close with the following painful but true reality, difficult as it may be to understand or accept, love is simply not enough.

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HANDOUT #14-1 Questions to Ask About Culture

Adapted from Saville-Troike, N. "A guide to Culture in the Classroom" Rosslyn VA: National Clearinghouse for Bilingual Education, 1978, 19-34

1. General

- What are the major stereotypes which you and others have about each cultural group? To what extent are these accepted by the group being typed?
- To what extent and in what areas has the traditional culture of each minority group changed in contact with the dominant American culture? In what areas has it been maintained?
- To what extent do individuals possess knowledge of or exhibit characteristics of traditional groups?

2. Family

- Who is in a "family"? Who among these (or others) live in one house?
- What is the hierarchy of authority in the family?
- What are the rights and responsibilities of each family member? Do children have an obligation to work to help the family?
- What are the functions and obligations of the family to the larger social unit? to the school? to its individual members?
- What is the relative importance of an individual family member vs. the family as a whole? What is the degree of solidarity of cohesiveness in the family?

3. The Life Cycle

- What are criteria for the definition of stages, periods, or transitions in life?
- What are attitudes, expectations, and behaviors toward individuals at different stages in the life cycle? What stage of life is most valued? What stage of life is most "difficult"?
- What behaviors are appropriate or unacceptable for children of various ages? How might these conflict with behaviors taught or encouraged in the school?
- How is language related to the life cycle?
- How is the age of children computed? What commemoration is made of the child's birth (if any) and when?

4. Roles

- What roles within the group are available to whom, and how are they acquired? Is education relevant to this acquisition?
- What is the knowledge of and perception by the child, the parents, and the community toward these roles, their availability, and possible or appropriate means of access to them?
- Is language use important in the definition of social marking of roles?
- Are there class differences in the expectations about child role attainment? Are these realistic?
- Do particular roles have positive or malevolent characteristics?

5. Interpersonal Relationships

- Is language competence a requirement or qualification for group membership?
- How do people greet each other? What forms of address are used between people in various roles?
- Do girls work and interact with boys? Is it proper?
- How is deference shown?
- How are insults expressed?
- Who may disagree with whom? Under what circumstances?
- Are mitigating forms used?

6. Communication

- What languages, and varieties of each language, are used in the community? By whom? When? Where? For what purposes?
- Which varieties are written, and how widespread is knowledge of written form?
- What are the characteristics of "speaking well," and how do these relate to age, sex, context, or other social factors? What are the criteria for "correctness"?
- What roles, attitudes, or personality traits are associated with particular ways of speaking?
- What range is considered "normal" speech behavior? What is considered a speech defect?
- Is learning the language a source of pride? Is developing bilingual competence considered an advantage or a handicap?
- What is the functionality of the native language in the workplace or larger environment?
- What gestures or postures have special significance or may be considered objectionable? What meaning is attached to direct eye contact? To eye avoidance?
- Who may talk to whom? When? Where? About what?

7. Decorum and Discipline

- What is decorum? How important is it for the individual and for the group?
- What is discipline? What counts as discipline in terms of the culture, and what does not? What is its importance and value?
- What behaviors are considered socially unacceptable for students of different age and sex?
- Who or what is considered responsible if a child misbehaves? The child? Parents? Older siblings? School? Society? The environment? Or is no blame ascribed?
- Who has authority over whom? To what extent can one person's will be imposed on another? By what means?
- How is the behavior of children traditionally controlled, to what extent, and in what domains?
- Do means of social control vary with recognized states in the life cycle, membership in various social categories, or according to setting or offense?
- What is the role of language in social control? What is the significance of using the first vs. the second language?

8. Religion

- What is considered sacred and what secular?
- What religious roles and authority are recognized in the community?
- What is the role of children in religious practices? What are they supposed to know or not know about the religion?
- What should an outsider not know, or not acknowledge knowing?
- What taboos are there? What should NOT be discussed in school? What questions should NOT be asked? What student behaviors should NOT be required?
- Are there any external signs of participation in religious rituals (e.g., ashes, dress, marking)?
- Are dietary restrictions to be observed, including fasting, on particular occasions?
- Are there any prescribed religious procedures or forms of participation if there is a death in the family? What taboos are associated with death and the dead?

9. Health and Hygiene

- Who or what is believed to cause illness or death (e.g., the "germ" theory vs. supernatural or other causes)?
- Who or what is responsible for curing?
- How are specific illnesses treated? To what extent do individuals utilize or accept "modern" medical practices by doctors and other health professionals?
- What beliefs, taboos, and practices are associated with menstruation and the onset of puberty?

- What are beliefs regarding conception and childbirth?
- What beliefs or practices are there with regard to bodily hygiene (e.g., bathing frequency and purpose)?
- If a student were involved in an accident at school, would any of the common first aid practices be unacceptable?

10. Food

- What is eaten? In what order? How often?
- What foods are favorites? What taboo? What "typical"?
- What rules are observed during meals regarding age and sex roles within the family, the order of serving, seating, utensils used, and appropriate verbal formulas (e.g., how, and if, one may request, refuse, or thank)?
- What social obligations are there with regard to food giving, preparation, reciprocity, and honoring people?
- What relation does food have to health? What medical uses are made of food, or categories of food?
- What are the taboos or prescriptions associated with the handling, offering, or discarding of food?

11. Dress and Personal Appearance

- What clothing is "typical"? What is worn for special occasions? What seasonal differences are considered appropriate?
- What significance does dress have for group identity?
- How does dress differ for age, sex, and social class?
- What restrictions are imposed for "modesty" (e.g., can girls wear shorts, or shower in the gym)?
- What is the concept of beauty, or attractiveness? how important is physical appearance in the culture? What characteristics are most valued?
- What constitutes a "compliment," and what form should it take (e.g., in traditional Latin American culture, telling a woman she is getting fat is a compliment)?
- Does the color of dress have symbolic significance (e.g., black vs. white for mourning)?

12. History and Traditions

- What individuals and events in history are a source of pride for the group?
- To what extent is knowledge of the group's history preserved?
- In what forms and in what ways is it passed on?
- To what extent is there a literate tradition of the history of the group (i.e., written history, and knowledge of written history within the group itself)?
- Do any ceremonies or festive occasions reenact historical events?
- How and to what extent does the group's knowledge of history coincide with or depart from "scientific" theories of creation, evolution, and historical development?
- What changes have taken place in the country of origin since the group or individuals emigrated?
- For what reasons and under what circumstances did the group or individuals come to the United States (or did the United States come to them)?

13. Holidays and Celebrations

- What holidays and celebrations are observed by the group and individuals?
- What is their purpose (e.g., political, seasonal, religious, didactic)?
- Which are especially important for children and why?
- What aspects of socialization/enculturation do they further?
- Do parents and students know and understand school holidays and behavior appropriate for them (including appropriate nonattendance)?

14. Education

- What is the purpose of education?
- What kinds of learning are favored (e.g., rote, inductive)?
- What methods for teaching and learning are used at home (e.g., modeling and imitation, didactic stories and proverbs, direct verbal instruction)?
- Do methods of teaching and learning vary with recognized stages in the life cycle? With the setting? According to what is being taught or learned?
- What is the role of language in learning and teaching?
- Is it appropriate for students to ask questions or volunteer information? If so, what behaviors signal this? If not, what negative attitudes does it engender?
- What constitutes a "positive response" by a teacher to a student? By a student to a teacher?
- How many years is it considered "normal" for children to go to school?
- Are there different expectations by parents, teachers, and students with respect to different groups? In different subjects? For boys vs. girls?

15. Work and Play

- What range of behaviors are considered "work" and what "play"?
- What kinds of work are prestigious and why?
- Why is work valued (e.g., financial gain, group welfare, individual satisfaction, promotion of group cohesiveness, fulfillment or creation of obligations to/from others, position in the community)?
- Are there stereotypes about what a particular group will do?
- What is the purpose of play (e.g., to practice social roles, skills training, muscle development and coordination)?

16. Time and Space

- What beliefs or values are associated with concepts of time? How important is "punctuality"? Speed of performance when taking a test?
- Is control or prescriptive organization of children's time required (e.g., must homework be done before watching TV, is "bedtime" a scheduled event)?
- Are particular behavioral prescriptions or taboos associated with the seasons (e.g., not singing certain songs in the summertime or a snake will bite, not eating oysters when there is an R in the month)?
- Is there a seasonal organization of work or other activities?
- What is acceptable presence or grouping of individuals (e.g., do children stay with adults and listen or go outside)?
- How do individuals organize themselves spatially in groups (e.g., in rows, circles, around tables, on the floor, in the middle of the room, around its circumference)?
- What is the spatial organization of the home (e.g., areas allotted to children or open to children, appropriate activities in various areas of the home)?
- What geo-spatial concepts, understandings, and beliefs exist in the group or are known to individuals?
- What is the knowledge and significance of cardinal directions (north, south, east west)? At what age are these concepts acquired?
- What significance is associated with different directions or places (e.g., heaven is up, people are buried facing west)?

17. Natural Phenomena

- What beliefs and practices are associated with the sun and moon (including eclipses and phases of the moon), comets, and stars?
- Who or what is responsible for rain, lightning, thunder, earthquakes, droughts, floods, and hurricanes?
- Are particular behavioral prescriptions or taboos associated with natural phenomena? What sanctions are there against individuals violating restrictions or prescriptions?
- What means are there for obviating the negative effects of natural phenomena?
- How and to what extent does the group's beliefs about these phenomena coincide with or depart from "scientific" theories?
- To what extent are traditional group beliefs still held by individuals within the community?

18. Pets and Other Animals

- Which animals are valued, and for what reasons?
- Which animals are considered appropriate as pets; which are inappropriate, and why?
- Are particular behavioral prescriptions or taboos associated with particular animals?
- Are any animals of religious significance? Of historical importance?
- Are there seasonal restrictions on talking about or depicting certain animals (e.g., except when hibernating, during hunting season)?
- What attitudes are held toward other individuals or groups which have different beliefs and behaviors with respect to animals?

Clinical Issues with Gay and Lesbian Adoptive Parenting

15

Michael Colberg, J.D., C.S.W.

Openly gay and lesbian parented adoptive families comprise an emerging minority group. The majority of these families remain concerned with the parenting of young children. Clinical issues, unique to this population will begin to present themselves as gay and lesbian parented adoptive families reach new developmental stages. This article outlines a model that addresses some of the clinical issues relevant to working with gay and lesbian parented adoptive families. Attention will be paid to three general areas: issues of engagement, issues that arise from both internalized and societal homophobia and issues concerning the structure and development of gay and lesbian parented families.

The engagement process begins with an understanding of the historical context on which we are working. Americans have had to redefine many of the ways in which we have traditionally thought about the nature of family. As our society has become more mobile, we have become less able to rely on our extended families. This has served to both isolate nuclear families and to place additional demands on their members to fulfill roles that, in the past, had been shared amongst siblings, parents, grandparents, aunts, uncles and cousins. The fifties brought television into our homes and the model for family structure became idealized by such shows as "Leave It To Beaver," "Ozzie and Harriet" and "The Donna Reed Show." The sixties and seventies left a legacy of individualism which gave many of us the courage to explore our personal identities and live our lives as the people we are instead of assuming the roles that we felt obligated to fill. This search for personal freedom placed additional burdens on nuclear families. Television programs like "Family," "Julia" and "All In The Family" reflected the fact that Americans were coming to understand that the idealized notion of family did not accurately represent the ways in which most of us were living our lives. Economic forces changed not only the complexion of the work force, but also the nature of family relationships. Today, most two-parent families are dependent upon two incomes. Children spend time in daycare. Almost half of all marriages end in divorce.

During the 1980s, several factors converged to create the opportunity for many gay men and lesbians to build families through adoption. Women's liberation served to help birthmothers demand a more active and dynamic role in creating adoption plans. Gay liberation empowered gay men and lesbians in ways which helped them redefine themselves as people who lived "alternate" rather than "deviant" lifestyles. The appearance of crack cocaine created a group of children who became known as "border babies." As they grew in number, these children began testing the resources available to hospitals and the social welfare system. Similarly, the impact that AIDS would have on our health care system began to be felt. AIDS was affecting not only gay men, but also heterosexual adults and their offspring. Slowly and quietly, homosexual homes were considered as foster homes for "border babies" and HIV infected children. Foster homes evolved into adoptive homes. As time passed, birthmothers began to consider and select gays and lesbians as adoptive parents. Gays and lesbians began to build families through pri-

vate adoption. Some agencies began to broaden their client bases and included openly gay and lesbian prospective parents.

As the pool of gay and lesbian parented adoptive families has grown, their impact has been felt in a number of ways. States have had to addresses the rights of these families. Courts have had to decide on the rights of gay and lesbian families to adopt singly or as couples. The families themselves have organized and established themselves as members of the national community. The increased visibility has led to increased vulnerability. During the past several years, gay and lesbian families have both won and lost important legal battles. What is most important to understand is that the political environment surrounding gay and lesbian adoptive families is fluid. Their very right to exist cannot be guaranteed. As this article is written, the potential exists in Washington state for a bill to be introduced into the legislature which would allow children to be taken from their parent's care on the basis of their parent's sexual identity. (Human Rights Campaign Fund Quarterly, Summer 1995) This opens the door for finalized adoptions to become vulnerable to vitiation.

Many of the changes that Americans have faced are unsettling. Many of us grew up during the age of the "idealized American family" and are burdened by the fact that the world that we expected to live in is gone. For many, too much has changed too fast. People do not feel that they have been supported or educated about how to function as a family in today's complex world. We long to "get it right." In fear, many cling to their idealized notions of what a family is supposed to be. Their disappointment is expressed as anger and rejection of those families and individuals who are most easily identified as different. An interesting paradox exists. Although we, as a nation, cherish our freedom and individualism above all else, we tend to discriminate against and pathologize those whose lifestyles are different from our own. This serves to keep us distinguished from "the other" and connected, in theory, to the "norm."

As the engagement process begins, it is important for the clinician to be aware that gay and lesbian parented adoptive families are seen as "the other." Having received a lot of attention from both the media and politicians, they have been portrayed as emblematic of the changes we have faced. They have, as a group, been both rejected and pathologized. It is important, when engaging with gay and lesbian parented adoptive families, to work systemically and to look at the environment in which they live their lives. Gay and lesbian parented adoptive families are not in a safe or hospitable "holding environment." As we have learned from working with other minority populations, a significant amount of stress flows from living under scrutiny, being exposed to discrimination and having the right to exist and to protect one's children when they come under attack. Additionally, studies have shown that minority groups who experience discrimination are less likely to seek and receive help. In order to successfully engage with gay and lesbian parented adoptive families, it is necessary to create a "holding environment" which allows them to feel safe enough to reveal their vulnerability, safe enough to learn about the issues unique to their population and safe enough to engage with the developmental challenges that they will face.

Questions emerge when beginning the engagement process. How can we work together most effectively? What might get in our way and how will these obstacles be addressed? Traditional social work practice dictates that the clinician start where the client is and help them to achieve their identified goals. Most adoption practice varies from this point of view and is more behaviorist in nature. The clients are presented with a program which they must accept or go elsewhere. The model outlined herein offers a hybrid approach. It is based on Dr. Joyce Maguire Pavao's "Brief Long Term Therapy Model" (in press) and is structured to allow the client family to go in and out of treatment as new developmental stages present. The model initially relies upon the creation of a working alliance that helps the client narrate his/her experience. It then helps the client to reframe his/her understanding by placing their experiences into a historical context. Once clinician and client have accomplished this task, the clinician is able to be more successful as he/she introduces the didactic material that explains the developmental challenges that the clients, and their families, are likely to encounter. This process normalizes the challenges and alerts the clients to those points in time when they might benefit from a return to treatment.

This approach addresses the resistance that emanates from a person being told what is right for them through the creation of a partnership between clinician and client. This serves to mitigate the feelings of being out of control that arise when seeking help and helps clients to remain open to integrating the didactic information that must be conveyed in order to help reframe the ways in which they view themselves and their situation. The model stresses the need to communicate to the client that the issues that they face are complex and that there are no ready answers. It also stresses the need to establish a collegial environment which allows clinician and client to form a partnership, view the landscape of the clients' lives, gain an understanding of the roles that society, their community, their friends and their family play in both supporting and challenging their development as a family, assess available resources and finally make and implement some long term strategies that allow the family to flourish.

The establishment of a collegial relationship can be facilitated in several ways. First, the clinician should examine and disclose those personal biases which are relevant to their working with the client. This helps clients to view the clinician as a fellow human being rather than as another authority figure. Each of us is engaged in a struggle with judgement and bias. Gay and lesbian parented adoptive families are, today, in a situation which exposes them to both. The clinician who is able to address and discuss his/her personal struggle models for the client that their growth as a family is a process and that they are being communicated with as people of value. This, in turn, supports the client's ability to enter the "holding environment" and reveal themselves.

Engagement is further facilitated as the clinician makes certain that the clients become aware of the historical context in which they are living their lives. As the clinician communicates this information to the client, he/she validates and normalizes many of the client's experiences in a way that helps the client to reframe their experience and feel understood. It is useful to think of gay and lesbian parented adoptions as being transcultural adoptions. These parents are not considered to be a part of the dominant culture even if they were raised in families that were considered part of the majority. As they came to identify themselves as homosexuals, they became, in a sense, "aliens." They live surrounded by a culture that considers them to be "different." They do not enjoy many of the rights afforded other members of society and their differences are often pathologized.The parent's relationship is not legally recognized and typically, only one parent retains any legal relationship to the child. In addition, and as has been well documented, homosexuals have developed their own cultural characteristics and the developmental stages of the homosexual individual differ from his/her heterosexual counterpart. Their children will, statistically, grow up to be heterosexual. As such, the family is comprised of both homosexual and heterosexual members. It belongs, in one sense, to both communities and in another sense to neither. Gay and lesbian adoptive parents need to be supported as they work to help their children learn to value their membership in both communities.

It is the clinician's responsibility to guide the family toward a long term view of what its needs will be. As people face the challenges in front of them, they tend to lose sight of the overview. If the community is not supportive of a gay and lesbian adoptive family, it seems logical, at first glance, for the family to withdraw and seek a more accepting circle of friends. This might mean that the family befriends and socializes only with other gay and lesbian parented families. This solution might give the parents the support they need at that moment but set them up for difficulty down the road. If a family becomes too isolated from the dominant culture, they might have a harder time helping their child integrate themselves into their peer group as they begin school. Part of our work is to help clients to understand that their current experience is a snapshot in time and that the goal must be to create a beautiful album. The needs and concerns of the moment must be tempered by an understanding that the needs of the coming years may be significantly different. As the clinician helps the client to see gay and lesbian adoption from a long term cultural perspective, he/she has the opportunity to join with the client and validate some of their feelings of stress and oppression. The clinician can begin to "hold" some of the client's feelings and help them to explore their long term needs. The clinician, by communicating an overview, both validates the client's sense of oppression and offers

the hope of learning how to integrate into the community.

During the engagement process, the clinician should use both ecograms and genograms to help the client relate his/her history and life experience. This process serves to facilitate the client's understanding of their immediate environment's strengths and stressors. As the client begins to describe their situation, the ecogram can be assembled. The map that emerges will concretely illustrate both the resources and the drains on those resources that exist. Are the parents "out" at work? Do they have a mixed group of friends? Are their families of origin a source of support or an additional stressor? Is there a parents' organization to which they belong? Do they socialize with other parents? Have the children made disparaging comments? Have teachers responded appropriately? Does the school community seem open to being educated about the issues that gay and lesbian parented adoptive families in their school community? Have their children asked questions about why they live with two same sex parents? Have they asked about adoption? Do the birth parents know that their child has been adopted into a homosexual parented home? Is this an open adoption? If this is a closed adoption, is it possible to open it if desired? The preparation of an ecogram helps the clinician to establish a "holding environment" as they sit with the clients and take a clear look at their resources so that they can begin to plan for the future.

Genograms are another way of fostering the engagement process. The clinician should do two sets of genograms. The first, of the client's nuclear and extended family, helps gain an overview of the patterns and dynamics that have existed over generations. This helps the couple to better understand themselves and each other, which tends to support and deepen their ability to parent as a team. Same sex couples have not been socialized into family roles. Learning about how they decide who is responsible for what is useful as it gives the client the opportunity to pay attention to some of the choices that they have made in a more conscious way. It also serves to identify some of the struggles that the clients may have had with their families of origin. How is their homosexuality integrated into the complexion of the family? Is their relationship sanctioned? How was the decision to build a family through adoption received by various family members? Has the family joined the client on their journey or has it been unable to come to terms with the client's decision to step forward as an openly gay or lesbian parent? The answers to these questions might lead the clinician to invite extended family members to join the clients in session as it is deemed appropriate.

The second genogram relates to the client's "family of choice." Many gays and lesbians have created their own "families of choice." This community works together in many of the ways that families of origin have traditionally interacted. The members have come to rely on each other and the relationships between members may, in fact, contain more intimacy than those between clients and their families of origins. As such, the children will, by being exposed to these relationships, learn a great deal about how members of their family relate to others. It is useful to spend the time with clients doing this second genogram as it helps them to frame and organize some of the ways they think about family dynamics. It also helps the clinician and client to identify any destructive patterns that may have been carried from the family of origin to their interaction with their family of choice, before they are passed on to their children.

Identifying and addressing the role that homophobia plays in the family is an equally important task. Societal, familial and internalized homophobia all play a role in the lives of gays and lesbians. Even the most politically liberal families may harbor prejudice against homosexuals. Parents may come to accept their child's homosexuality but be shocked by the decision to parent through adoption. Homosexuals are expected to be childless. Parents may not have told their friends and colleagues about their child's sexual orientation. The act of becoming a parent "outs" gays, lesbians, and their families of origin in new ways. It is difficult for a gay or lesbian couple to remain secretive about their relationship and sexual orientation once they decide to parent. Maintaining the secret places an enormous burden on the child and engenders shame in all family members. Secrets are poisonous and demolish self-esteem. Privacy, on the other hand, is important. It is the clinician's responsibility to help the client understand the implica-

tions of the decision to parent. Clinicians can help their clients come to a place where they feel comfortable about maintaining their privacy while growing past their need for secrecy. It is helpful to work systematically when working with clients who become stuck and need help in discerning the difference. If possible, work with the clients toward inviting extended family members into sessions so that together, they can learn about the nature of adoption and more specifically, gay and lesbian parented adoptive families. At stake is the child's ability to maintain a relationship with extended family members and feel comfortable with their place in the world. The connectedness that derives to parent, child and grandparent goes a long way toward healing and supporting the development of healthy self-esteem. It also helps the child understand that some family members are heterosexual and some are homosexual, that they are all in the same family and linked together. The clinician should underscore the importance of helping the child to learn to value all of his/her pieces. Differences are present and accepted. Interacting with these differences can serve to help all family members grow in unexpected ways. The positive modeling that derives from watching a family acknowledge and address its remaining homophobia can serve to support the child as he/she develops the skills necessary to negotiate his/her way in the community.

Internalized homophobia plays a significant role in the lives of many gay/lesbian adoptive parents. The clinician who can help a client identify and address internalized homophobia, and its resultant shame, greatly strengthens the client's ability to parent their child as similar issues, related to their child's status as an adoptee, begin to emerge. As mentioned above, society does not support homosexuality and laws speak to whether or not a jurisdiction is allowed to discriminate against this group of citizens. This acts to infantalize gay and lesbian parents. A parent may feel shame, anger, rejection, loss of identity and grief as they become aware that they and their family are being treated differently from heterosexual families. A parent's primary job is to make certain that their child is safe and this is made difficult when a society dictates that the parent and child may have no legal relationship. The feelings of shame and anger engendered by a parent being denied the opportunity to fully execute his/her responsibilities must be addressed. The homeostasis existing in the parents' relationship may suffer from the failure of our society to recognize the integrity of the family boundry. Reactions may take the form of difficulty in achieving intimacy, in the emergence of control issues and in a loss of self-esteem. These feelings tend to become pathologized. The clinician should work to both validate and normalize these feelings as being appropriate responses to the ways in which homosexuals are accepted by society. Paradoxically, adoptees are also infantalized and often wrestle with many of the same feelings. Adoptees are not participants in the decisions made around their placements. They have no control over their access to birth families. They are often denied access to their biological and medical histories. Their birth certificates are rewritten and their records are sealed. Silverstein and Kaplan (1986) detail and discuss seven core issues that adoptees, adoptive parents and birth parents can be expected to wrestle with at various times in their lives. These include loss, rejection, guilt/shame, grief, intimacy, identity, and control. As these feelings present, clinicians have the opportunity to work with gay and lesbian parents in exciting ways. Typically, neither homosexuals nor adoptees are socialized into minority status by their parents. Gays and lesbians generally have heterosexual parents and adoptees most often are raised by parents who entered their families biologically. Homosexual parents who have successfully learned to integrate their minority status and engage with the feelings resulting from internalized homophobia have the opportunity to help their children to coexist with their feelings and grow into emphatic adults.

Parents pay a price when they are secretive about their status. Clinicians need to become aware of whether there are any areas in the client's life where they continue to hide their homosexuality and their status as a gay or lesbian adoptive parent. This, again, should be distinguished from the client's right to privacy. The clinician should also be alert to any discomfort that the client might have with other homosexuals. This may indicate some lack of acceptance by the client of their own sexual orientation and further, may model for the child that their are some parts of themselves which are "bad"

and unacceptable. Parents should be supported while they explore any lack of self-acceptance. It is clinically helpful to frame this discussion in terms of helping the parents learn to teach their children how to accept all of the parts that make them who they are. Conversely, clinicians need to help those clients who have rejected the heterosexual world to come to an understanding of their status as a family consisting of both homosexual and heterosexual members. Their child's status as a probable hetereosexual dictates that they need to begin to help the child learn how to maintain connections in both communities. Failure to do so will cause the child enormous pain and could cause them to "split off" their homosexual parents as they explore their heterosexual identity.

Another way that homosexuals can respond to societal rejection is by overachieving. They may strive to do everything a little more successfully than their heterosexual counterparts. They may wear only the best clothes, go to the best restaurants, drive the hottest car, have the most stylish apartment and build the best body. Clinicians should be alert to the fact that adoptees often experience developmental lags. Adopted children have additional information and issues which they must process as they grow. This added challenge may make them appear to lag behind some of their counterparts. The children being parented by gays and lesbians have even more complicated issues with which to contend. Whereas children adopted into heterosexual homes are often able to defer conversations with peers about their status, children adopted into gay and lesbian homes are subjected to scrutiny as they have parents who are visibly different. Processing these differences may take a lot of energy away from other developmental tasks and result in lags. Clinicians should be aware of the pain that this might cause homosexual parents who have reacted to their feelings of rejection and inadequacy by overachieving. The work here is to support the parent while they learn to reframe their feelings about the rate of speed at which their child is developing.

Internalized homophobia can also impact upon the ability to develop and maintain intimacy. The feelings that derive from feeling ashamed and rejected impact on the ability to maintain good self-esteem. Although it is possible to deny the existence of these feelings by maintaining a very structured life where one is able to control the degree of closeness affected in any given relationship, the nature of parenting works against being able to successfully maintain this mode of coping. To maintain a distance from one's child brings great sadness to both parent and child. Each will come to feel that there is something wrong with them. When clinicians are confronted with this issue, they are well served to help the client identify their goals. What kind of relationship do they want to have with there child? The distancing should then be framed as an obstacle which lies in the way of their achieving this goal. As they come to understand the etiology of this defense and experience the sadness and disappointment around its existence, the clinician will have the opportunity to work with the vulnerability that ensues and help the client to foster a stronger and more satisfying connection with their child and with their partner as well.

Clinical work involving gay and lesbian adoptive families must also include a good deal of psychoeducation intended to inform them about the developmental challenges that they are likely to encounter. Although the scope of this article does not allow for a detailed discussion of the various stages encountered by gay and lesbian parented adoptive families, the highlights are listed below. Dr. Joyce Maguire Pavao describes the challenges that are unique to the development of adoptive families. *The Normative Crises in the Development of the Adoptive Family*, Pavao's seminal work served to alert us to the fact that adoptive families differ from those formed biologically. Her work normalized and depathologized the experiences encountered by families formed through adoption. Gay and lesbian parented adoptive families encounter developmental issues that are unique to their population. The clinician both supports and strengthens the client's ability to parent as he/she teaches the client about the developmental challenges that the family can expect to encounter. As gay and lesbian parents are helped to understand their families developmental cycles, they are empowered to support their children as they negotiate their way through the next developmental stage and can better identify the times that they and their children will benefit from a brief return to treatment.

Preplacement issues include a reworking of the "coming out" process and a renegotiating to the parent's relationship. As mentioned, homosexuals are expected to remain childless. Both the heterosexual and the homosexual communities have been slow to embrace the concept of gay and lesbian adoptive parenting. As such, as gay and lesbian preadoptive parents disclose their intent to adopt, they may find themselves, once again, at odds with their peer group. Clinicians should address this by helping clients to become conscious of the impact that their change in family status has on their identity. The ways in which families of origin have reacted to their children's homosexuality may also need to be reworked. The entire family becomes exposed as having homosexual members once a gay or lesbian couple decides to parent. The whole family may become exposed to the scrutiny and prejudice previously experienced only by the homosexual members. The clinician can frame this process in a way that may allow the homosexual children to help their parents gain insight into some of their children's struggles. Although painful, the result can be deepening of the parent and child relationship which can, in turn, be a great source of support for the fledgling family.

The couple should be helped to anticipate some of the ways in which its relationship will be changed. There have been no role models for openly gay and lesbian parents. There has been no socialization process for the assumption of parenting roles. Both members of same sex couples have been socialized, by their families and society, into the same roles. This creates some awkwardness but also allows for the clinician to help the couple to make very conscious decisions as to the ways in which they will work together to parent. During this period, it is important for clinicians to strengthen their client's self-esteem through psychoeducation. Validating and normalizing the client's experience strengthens their feeling of empowerment and underscores the fact that they can rely upon the working alliance that has been established between client and clinician.

The law, in most jurisdictions, continues to deny one parent the opportunity to have any legal relationship with the child. This serves to impact upon the couple's power dynamic. One member of the couple suddenly has a good deal more power than the other. How will this change affect the interaction between them? What feelings emerge as this realization hits home? As mentioned, homosexuals are already made to feel powerless in society. The safe haven of their relationship may be disrupted by their inability to equally share in the legal relationship to this child. The clinician should address this issue and help the clients to process their feelings. The entire legal process attendant to placement can be far more laden than for heterosexual couples. The pressure that comes with worrying about the reaction of the birthparents, the judge, and potentially the media and the legislature should be anticipated. Clinicians serve their clients by introducing discussion aimed at helping clients to weigh the advantages of disclosing their status as a same sex couple. Although it may seem much easier for only one member of the couple to step forward and to adopt as a single parent, the implications on the family, over time, should be understood. The clinician can facilitate this process by helping the clients to take a long term view of their family's needs.

Several key factors arise at the time of placement. Birthparents, in private adoptions, may come under pressure to rethink their decision to place with a same sex couple. This pressure may come just as the birthparent is feeling most vulnerable. Anticipating this, the clinician should help the clients to discuss this with the birthparent prior to delivery. This discussion affords the clinician the opportunity to help the client and their birthparent come to understand that adoption begins at placement and is a life long process for all concerned. Discussing difficult issues helps lay the groundwork for a relationship based on trust and, over time, the establishment of real intimacy. The support offered by birthparents can go a long way toward supporting the gay and lesbian adoptive parent as they reenter society in their new status. Whereas society generally embraces newly formed heterosexual families, gay and lesbian parented adoptive families are often not afforded a very warm welcome. When this happens they may be left feeling isolated. The clinician can be of great support to parents as they learn to act as ambassadors and work to educate their friends, families and communities about the nature of gay and lesbian adoptive parenting. It is useful to help the client

understand that they have done a lot of work to come to where they are and they need to be patient with others as they begin their journey towards acceptance and welcome.

As the child develops an awareness of his/her surroundings, he/she realizes that his/her family structure differs from those of almost everyone else. The child sees that he/she is missing either a mother or a father, something most of the other children have. This can engender feelings of sadness, insecurity and confusion that may tap into feelings shared by gay and lesbian adoptive parents. The clinician can be helpful by framing things in such a way as to facilitate the parent's ability to validate the child's feelings. This, in turn, serves to deepen the trust and connectedness experienced between parent and child. The parent is able to say that while their family is differently structured, it is both valuable and viable. As the child develops cognitively, the parents can help the child learn about the difference between privacy and secrecy as they begin to respond to questions and comments from their peers and others. In order to be most effective, parents need to be supported as they develop their own feeling of ease in their interactions with society.

As the child enters school, they will seek to be accepted by their peers. Their feelings of being different may very well rekindle, for gay and lesbian parents, the feelings that they had during their own school years. The danger here is that the parent will begin to feel the shame that they felt long ago and may experience guilt for causing their child to suffer. The clinician should support the parents and reframe the parents' experience in a way that allows the parents to use their experience as a basis for the development of greater empathy for their child's struggle. Gay and lesbian parents are uniquely situated to be able to build a powerful connection with their child as they help them to negotiate some of the same challenges that they have faced. Parents must also be supported as they work to become visible members of the school community. Curriculums do not, as a rule, include materials that include differently formed families and this can make the child feel invisible. Clinicians should help parents to find ways to have gay and lesbian adoptive families become represented. This calls for some creativity on the part of both parents and clinicians, but is well worth the effort as it works both to support the child's membership in their peer group and validates the parents' feelings of belonging to the school community in an active rather than reactive way.

Adolescence is complicated for all adoptees. It is the time that children become adults and wrestle with who they are in the world. It is also the time children begin to explore their sexuality. The children of gay and lesbian adoptive parents may need to separate themselves from their parents as they explore their heterosexual identities. This process can be very painful for all family members and can be mitigated by the creation of strong connections to heterosexual role models throughout the child's minority. Relationships with birthparents, extended family members and friends can serve to create a "holding environment" which allows the family to both maintain its connection and gain the distance that they may need to work through this developmental stage. This is a time that the family should be encouraged to return to treatment if they feel discomfort. Feelings can get very complicated as the child addresses a stage that, for most homosexuals, was filled with despair and self-loathing. Psychoeducation is an extremely important tool during this stage as it helps frame much of what is going on in a way that allows some distance from the parent's psychodynamic responses.

The model outlined above briefly describes ways in which the challenges facing gay and lesbian parented adoptive families can be addressed clinically. The establishment of a strong working alliance is essential to the success of this approach. Families are supported as they learn about where they come from, who they are and where they might expect to go. Of course, each family has its own dynamics and clinicians can encourage their client's individuality by establishing a collegial relationship which allows for the family to go in and out of treatment as they feel it necessary. As each period of treatment comes to an end, clinicians should spend some time predicting what the next challenge might be so that the family can be alert for signs that may indicate its arrival. This serves to further support and normalize family development in a positive way and helps the family internalize its therapeutic experiences.

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Searching…Reunions… Aftermath

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Let's start with making my bias clear. I am in favor of searching for an adoptee's biological parents. I am even more in favor of not having to search because nothing is hidden or secret. However, as long as records are sealed and identifying information is not readily available, I am in favor of manipulating, outsmarting and/or circumventing the system and getting the information.

I am, however, not some Pollyanna who believes that reunions mean living happily ever after, nor am I frightened at what people who search may find, nor am I in favor of giving people wrong information because it is a form of protecting individuals from harsh truths. One of the old and continuing problems is that adoption, as an institution, is riddled with lies; not malevolent lies, certainly, but perhaps well-intentioned loving lies that were mistakenly meant to make everything better; lies that were considered necessary to reach certain goals; lies that protected everyone supposedly forevermore.

The birth mother and birth father often lied because they wanted to make sure their baby would get a good home, or because they were afraid that the truth would make placement difficult. They also often wanted to use false names to keep everything hidden. No one thought that the adoptee might want to find birth parents and how aliases would make that difficult or impossible. In independent adoptions, it was not unusual for arrangements to be made for the pregnant woman to go into the hospital using the adoptive mother's name, so no legal adoption was necessary. This is still going on in foreign countries. My friend from India, who lives here, went back to Delhi and did just that. She stayed away for six months, and no one here knows the truth. I also know a young man who is at a total dead end in searching, because here in Los Angeles his mother, a school teacher, afraid her family would not accept an adopted member, did exactly the same as my friend in Delhi.

The couple who applied to an agency to adopt also lied, because they were afraid they would be rejected if they told the truth. They had to project themselves as great paragons of virtue, goodness, wholesomeness, and so on. No black marks, no negatives were permitted. They were correct in their assumptions. Agencies were looking for perfect couples. Agencies were looking for people who had no problems and never had had any problems. Agencies didn't think about the fact that they were giving couples a problem when they gave them a stranger's child to raise, and that couples who had had problems and knew how to cope might be better prepared to raise an adopted child. Couples who felt uncomfortable or unattracted to a child they were offered were afraid to say so, for fear they were ruining their chances of ever getting a baby. I knew a woman who was a child of Holocaust survivors. When she was offered a baby whose parents were of German background, she had an immediate negative reaction, but was afraid to tell the social worker, because that might ruin her chances forever.

The social worker lied, because she was afraid the couple would reject the baby if they heard any bad background information. And she was also afraid that she would load them with facts that would hurt the adoptees' feelings later on, if told the truth. She only described positives, rationalizing that the child needed a positive image of his/her heritage. She also lied to the adoptive parents, stating with absolute certainty that their child would never search if the adoption was a good one. She certainly lied to the birth mother, telling her that she was giving the child out of love, had resolved

the experience, and could now go on with her life, putting the whole thing away forever.

The adoptee lied, because he (or she) didn't want to hurt the people who had rescued him, and because of fear of a second abandonment if he was too interested in his other set of parents. Adoptees got good marks for showing disinterest in their background, and vowing no interest in searching. Many adoptees felt they had to wait until their adoptive parents died before searching, or made sure they kept their search and reunion a secret from the adoptive parents.

I think it must be recognized that most of the birth parent and adoptee population do not search. Why? There are probably many, many reasons, but chief among them has to be the difficulties inherent in the process, the energy and money needed, guilt, fear, lack of feeling entitled, and inertia. I did not use the word disinterest; certainly there is some of that as well, but I don't think that is a major reason.

Also certainly there are those adopted persons whose adoptive experience has been so devastating that they are trying to find a parent or set of parents to nurture them. I think they are a small minority. The majority of searchers are not looking for a mother or father. They are, in my view, looking for a missing piece of themselves.

There is a difference, I believe, when the searcher is the birth parent. Whereas the adoptee is not usually looking for a parent, I think the birth mother (and/or birth father) is unconsciously looking for the lost child. Even when the initial searcher is the adoptee, when a reunion is effected, the birth parent often receives and perceives this as a way to reparent the child. Since a significant percentage (as high as 38 percent) of birth mothers never marry or have other children, they are in reality emotionally reclaiming their child. Even for those who have had other children, the other children never replace the one relinquished, and the situation is similar. Because of this difference between the perceptions of adoptee and birth parent, the reunion process may encounter difficulties, which we will return to later.

There are certain truisms that surround the search. Two we have already mentioned: Adoptees search to find themselves, and birth parents try to recapture parenting the child. Now a few more: Adoptive parents remain fearful of losing their child's love, and also fear that their child, given the opportunity, will leave them for the "natural" parents. Even when adoptive parents are supposedly in favor of helping their child search, they have a limited image of what the reunion will be like, and they hope to maintain some control of the relationship. Another truism: The reunion does not weaken the adoptive family relationship; on the contrary, it is a powerful tool in the adoptee's realization that the rearing family is the close attachment, and that birth family members are essentially strangers whose roles are often ill-defined or need time and care to solidify into workable relationships.

There is no other relationship like that of the relinquished child/adult and the relinquishing birth parent or parents. Other relationships can be described in terms that use other models to make it understandable, but it is not so for the reunion after the search in adoption situations. I have heard many birth mothers speak of their great love for the child they relinquished. What do they love? The memory of the pregnancy and delivery, the sight and maybe holding of the newborn, the farewell, and then years of dreaming and imagining and yearning? That is certainly a kind of special, inviolate, perfect love, but it has little to do with the grown person of the reunion.

The adoptee has separate fantasies, and probably a more complicated, layered feeling toward the birth mother and father, with more anger and resentment and despair woven throughout. It is hard for the adoptee to put together the young, desperate birth mother at the time of relinquishment with the mature older person at the time of reunion. It is hard for the adoptee to accept the change in cultural mores and to believe that the birth mother felt truly unable to raise a child born out of wedlock alone.

Another truism: Even if the reunion does not make life beautiful for the participants, it is valuable and meaningful and finally, on one or another level, good to have been undertaken.

Is there any way to predict which adoptees or birth parents will search? Probably not with any great accuracy, but certain things are clear. Some people have to solve mysteries, have to have answers to questions. They are by nature greater risk-takers and searchers in *all* avenues of their life.

Other people are more timid and fearful, or eager to preserve peace, or satisfied with the status quo. They would rather let things be without disturbing the surface or stirring up the broth. I think that if I were adopted, I would have to search. I am sort of a troublemaker, a wave maker. I like to travel to exotic places, even if they are a little scary. In my youth I enjoyed saying outlandish things and being sort of radical. It's all part of the same personality profile.

If I had relinquished a child, would I go searching? That's a bit harder to answer, because birth mothers for many years did not feel they had any rights. They were indoctrinated with the notion that they had made a decision and had to stick with it. The way the script read was that adoptive parents agreed to adopt, birth parents agreed to relinquish; only the adoptee had no say in the matter, so only the adoptee has the right to go looking for his or her origins. Many birth parents were also stuck with the feeling that society did it to them, that they were somehow forced to relinquish against their real desires. Since they were not able to accept real responsibility in the decision-making process, they often remained stuck on the plateau of powerless rage.

Early in my conversion from adoption professional to adoption iconoclast, I believed that only adoptees over age 18 had the right to search. Slowly I accepted the notion that birth parents had equal rights, and I also stopped being afraid of intruding on the birth parents' lives. I began to realize that birth parents were the hidden group who didn't know whether their children were dead or alive, and finding them or giving them the right to find their relinquished offspring was a great gift. I also came to believe that opening closed adoptions at any time was a good idea, and that one did not have to wait until any arbitrary age.

Finally, let's get on to the search. Many adolescents become obsessed with wanting to search, but it is generally accepted that most of them don't have the glue to stay with the process. It is far more of a rebellious notion as part of their path toward separation and individuation. The adoptee has this one more weapon than the non-adoptee in his arsenal for severing that umbilical cord.

However, there are adopted folk who knew all their lives that when they grew up, they would search and find their roots. They never deviated from that plan. They are not the rule, but rather the exceptions, I think. It is rather accepted that most serious searchers are women, not men, adoptees, and that they reach the serious stage when they marry, become parents, or contemplate parenthood. In my experience, men adoptees usually have a strong motivated spouse pushing them into searching. One might conjecture that for the adopted woman or wife of an adopted man, the notion of motherhood evokes the image of the first birth mother experiencing childbirth, and facing the notion of relinquishment. Until that stage in the adoptee's life, that image of the birth mother has not presented itself that clearly. The strong feelings evoked by gestating, birthing, and bonding finally make the adoptee stop and suddenly relate to what it must have been like for that birth mother. Adoptees have described that wakening as powerful and poignant. They also for the first time have someone, their own child, who is their blood relative, who may look like them.

The steps in the search deserve some consideration. First there is the awakening desire to search, which becomes more pressing as time goes on; then the decision to search, the efforts to find out how, the commitment to engage in the tedious work associated with searching; the continued frustration, exhaustion, and times of hiatus, disgust, and despair; reengagement in the effort; and finally the success of bridging the secret, finding the information, and knowing that it is possible to make the contact at last.

There are of course those who do not succeed and flail around because they have no access to the information they seek. For some it is a solitary affair with professional help. For others it may involve becoming part of search groups and meeting and knowing others who feel the same way.

Recently I spoke at a triad group, one I had been at before. They asked me to speak about angry adoptees and good adoptees. We decided that all adoptees were probably angry, but some masqueraded as good, and hid their anger well. The group had both birth parents and adoptees, and that evening they invited adoptive parents to attend.

Usually this group bars them, because they feel inhibited with their presence. One of the adoptees at the meeting has had the necessary information for months, but she is not ready to contact her birth mother, and the others don't understand her reluctance. Particularly, the searchers who can't get the information look at her and let her know that if they had the information, they would call immediately. But they don't have the information, so it's easy for them to take that position.

There are not just angry adoptees, there are also angry birth parents. They are usually the ones who are having trouble establishing a relationship with their birth child. They are the ones who feel the adoptive family has all the power, and they have none.

In the search period, there is great help available, from professional searchers (who may have started out as amateur searchers/adoptees and have learned enough to make a career out of their self-taught knowledge) and from other members of the triad, who provide aid, empathy, sympathy, encouragement, excitement, and ideas. They are all virtual Sherlock Holmeses or Hercule Poirots, so smart and shrewd and creative in their search. Both adoptees and birth parents have told me how meaningful these groups were in establishing for them the basic feeling that they were not alone in their needs and yearnings. Deep, good friendships have grown out of these groups.

In the search there may occur an incredible number of coincidences that belie the imagination. My favorite perhaps is the 38-year-old adopted woman I know who is very mystical. She put an ad in the *Los Angeles Times* personal section, identifying herself, whatever birth name she had access to, her birthdate and place, and asked anyone who might know her birth mother to reply. I have to emphasize that I know this to be a true story. Her birthmother had confided in one person, and one person only. That person read the personal column that day, saw that ad, and contacted the adoptee, which led to the reunion. To me this was a staggering occurrence—but not to the adoptee.

A year and a half ago, I participated in a conference in Vancouver, British Columbia, organized because Canada passed a law opening sealed records with the help of the government agencies. The planners felt a need for this meeting because they knew that many adoptees and birth parents were floundering in and emotionally unstrung by the reunion experience. They felt that they needed to develop guidelines to help members of the triad cope with the realities of reunion. We gave workshops dealing with all the pre- and post-search and pre- and post-reunion issues from the point of view of all involved, including the extended families of the birth and adoptive relatives.

The search may be difficult, frustrating, depressing, and on and on, but the reunion is really the frightening eye of the storm to deal with. That is why that young lady who has all the information she needs is sitting without going any further. I am sure that all of you can give me ten reasons to be fearful and worried. Without any question, for me, the main reason is clearly *fear of rejection*. This is true for both adoptee and birth parent. Let us remember that the adoptee has already lived with the feeling that the birth parent rejected him or her initially, abandoned that baby who was unworthy of being kept; or however that relinquishment was integrated and internalized. To try again and to worry that the same scenario will be repeated is something you can hear from every adoptee in one form or another. The birth mother or father fears rejection, but a bit differently. Most of them could consciously tell you that what they did was unacceptable, and they have never forgiven themselves for giving away their child, even though they may also feel they had no choice and it was someone else's pressure. They assume that their offspring hates them, perceives them as bad and sinful and unworthy, and will not welcome their arrival on the scene. So both parties are fearful of not being welcome.

Furthermore, they don't know how to make the connection, because it is such a sensitive issue, and the initial words and way of introducing the relationship seem so difficult to effect. There are many scenarios written in the triad groups, many do's and dont's, and much hyperventilating and sweaty palms before, during, and after. The ability to make the contact one-on-one without involving other people is crucial in the minds of many. To have to go through parents, siblings, or others makes it that much more complicated. There are so many fantasies about the meeting and the feelings that are far above any normal piece of reality. As I

mentioned earlier, there is nothing to relate this relationship to in previous experience. It stands all alone, and therefore, without a counterpart, the road is often pitted, detoured, foggy, and unlit.

Some people favor using an intermediary to make the original contact; most feel it is too personal and sensitive to be given to another to do. Having learned from experienced adoptees and birth parents, I have become rather adept at advising people about important things to focus on. Certain feelings appear to be constant during the reunion process.

The first one or several contacts are very "iffy" and "scary", and finally when the searcher's whole body is submerged into the icy or boiling water, there is relief and breathing returns a bit to normal. Some reunions are rushing, pell-mell adventures; others are slow, measured, and tentative; some reunions are very brief and never go anywhere after a few meetings. However, certain things are pretty universal. If a reunion is meeting everyone's expectations and there is elation and euphoria, there will be a wonderful honeymoon period beyond expectations. I can absolutely guarantee that following the honeymoon there will be a period of snakes in paradise, small and large areas of difficulty, and need for continuous adjustment, readjustment, and reality testing. The start of the reunion is not necessarily any indication of the future of the relationship.

The parties to the reunion are also not necessarily at all equal in their perceptions, expectations, and modes of operation. Just as adoption is now considered a lifelong process, this is a part of that life process, and its development can go on with starts and stops and realignments for decades. Not only are the main participants affected by the reunion, but all of the extended families on all sides are also affected.

If all of this is true, why do I think reunions are so good? You have a right to ask that question. Even though there are many problems and frustrations, I don't know any party to reunion who does not feel that the reunion was valuable, a valid pursuit, and worth repeating. So while reunion is a brief piece of the action, post-reunion is a lifetime. Some folks really do finally arrive at a solid, meaningful relationship of whatever intensity works for them. Some folks agree to abort and see the reunion as answering questions and meeting needs, but feel no reason to continue. Some folks feel distantly connected and maintain a good acquaintance, a holiday-card, happy-birthday relationship. Some folks arrive too late for the main connections, because the birth parent or parents are dead, and so settle for finding out about the family. For a growing number of adoptees, sibling relationships are easier than parent/child ones. Just as adoption severs a connection, reunion cannot put it back together again the way it was before the amputation took place.

In working with people who are contemplating searching and reuniting, it is important for the therapist to try to ground the patient/client in reality. It is important to explore expectations and help scale them down to a more usable and workable path of growing connections. It is important to find out what the person thinks she or he wants from the relationship, and then what his or her hidden agenda is. It is extremely important to be very clear that there is no way to undo all the years of separation, and nothing makes up for that disconnection. Underlying feelings of blame, rage, anger, guilt, fear, and titillation will all be present in some degree.

The reunion is the best breeding ground for runaway acting-out behavior, where impulses are racing without any brakes being applied. One of the hidden, whispered-about areas between parent and child of opposite sexes is sexual attraction, frightening, exciting, toyed with, and unfortunately too often acted-out, with difficult and sometimes disastrous consequences. In the general population, father/daughter incest is more common than mother/son incest. It is my opinion that in reunion situations, the opposite is true. It's not difficult to understand: Most reunions are initially with the mother, and all the fantasies for years have been much more about the mother, the good and bad mother who abandoned the child. Not everyone agrees with me, but I think that just as rape is not sexual attraction, but rather a form of violence that uses that mode, I think the consuming rage of some adoptees is covered with the film of genetic sexual attraction. I think that it is one good way to gain revenge against the mother and to destroy her. However, there certainly are other examples of

truer genetic sexual attraction. The birth mother is often much younger than the adoptive mother; the difference in age between the adoptee and birth mother may only be fifteen or so years. The birth mother, if young and sexy in appearance, and so loving and vulnerable, offers an irresistible love-object. To the birth mother, if the son reminds her of the birth father and reawakens old images of that lusty time, it is also a rather irresistible situation, without all the taboos of family life.

I think that the therapist has a very strong directive role to play in such potential situations. I have seen the consequences, and they are frightening, potentially lethal, and irreversible. Generally speaking, the therapist should represent caution on all levels, with relined brakes offered at every juncture. One small example that I have learned is that it is good to emphasize that the people meeting are reality strangers, even if not fantasy ones. It is far better to go slowly, or as slowly as possible. Staying in the home of the birth parent or adoptee is not a good idea. Relief from the intensity of the connecting period together must be available. Neither party should coerce or pressure, but when that happens, the other party should be given complete permission to withstand and to withdraw temporarily or more permanently, if the situation is too complicated and frightening. If there is a self-help group available, it is an excellent adjunct to recommend.

Finally, the reunion, as has been already mentioned, does not stand alone. While it would be nice to focus on one area at a time, that is not the nature of the beast. I remember a birth mother who didn't tell anyone in her family or even her closest friends about her daughter finding her, and her daughter became enraged at being considered a dirty secret. I have known many adoptive families, emotionally undone and frightened by the reunion, who put the adoptee in a, "Who do you love more, who do you choose?" bind. The other children of the birth mother or father may feel slighted and ignored while the passion of the new relationship is on center stage. The spouse of the adoptee or birth parent may exhibit great jealousy after initial support, because his or her limit has been reached. The siblings and other relatives of each family may all put in their two cents to further complicate the situation.

Finally, the sands sift down, and there is a rapprochement. Because the terrors are over, the dangers are diminished, and the families go on enriched, or at least not destroyed. Mainly, the principals in the drama have met some unmet needs, found some missing pieces, and started to heal the old wounds that were festering without ever developing new skin.

As therapists, working with triad members during these difficult times is challenging. It demands that you retain your judgment and not be carried away by the excitement of the experience. It means that you need to counsel your clients and patients to take time to explore feelings, to leave doors open, and to walk carefully through the tangled terrain.

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Endnotes

This book is by no means a complete look at issues of the adoption triad (adoptee, birth family, adoptive family). For instance, articles on the African American family and adoptions and impact of special needs adoptions on marital dyad were not submitted. The articles included do largely reflect course material covered during the two seminars and we hope these articles will launch further discussions amongst professionals as they gather in communities across the nation. We have a great deal to teach each other through local mentoring groups. The Kinship Alliance has found it enriching to include a broad spectrum of knowledge in all discussions. Input from the fields of sociology, anthropology, pre and peri-natal psychology, religion and education have been crucial as we seek to further our wisdom and awareness in today's populace. We have too long separated out adoption from examination of larger kinship issues in society.

Kinship Alliance is moving forward with a variety of programs. For more information, please contact Sharon Kaplan Roszia at the Kinship Alliances offices located at 513 East First Street, Second Floor, Tustin, California 92680.

Annette Baran
Sharon Kaplan Roszia
On behalf of all the participants
in the project.

About the Authors

Annette Baran is one of the nation's best known veterans of the reform movement in the field of child welfare and adoption. She has co-authored two landmark books: *The Adoption Triangle* and *Lethal Secrets*, has appeared on national network news, talk shows, and has been quoted in many news publications, including *Time*, *Newsweek*, *McCalls*, *Good Housekeeping*. Her articles have appeared in numerous anthologies, encyclopedias, and professional journals. She has lectured all over the world, and testified in national cases on issues including surrogate motherhood, contested custody, child abuse, and adoption.

Frances Chikahisa, MSW., LCSW, has been a private practitioner for over 25 years, with 20-30 percent of her practice consisting of adoption related issues. Ms. Chikahisa's counseling has often dealt with adolescent adoptees struggling with identity issues. More recently she is a co-therapist of an adoption triad support group which assists all members of the triad to share and support one another in their loss and grief issues. She is particularly concerned with the future of Asian babies being adopted at this time.

Michael Colberg, J.D., C.S.W., is the Co-director of New York's Center for Family Connections and a member of the Boston / Cambridge Pre / Post Adoption Consulting Team (PACT). He has lectured on adoption at Harvard, New York University, Hampshire College, the Post Graduate Center for Mental Health and the Institute for Human Identity, and has conducted trainings for the New York City Board of Education and a number of primary schools. He has written on gay and lesbian parenting for New York's "Kids Talk" and "In the Family" Magazine. Mr. Colberg also maintains a private practice in New York where he specializes in issues relating to adoption and foster care. While living in Los Angeles he served on the Los Angeles Commission for Children's Services and, together with his partner Gene, became the first couple to complete a second parent adoption in Southern California. He is especially proud of his daughter Rachel.

Susan Soon-Keum Cox has worked with international adoption and child welfare issues for more than twenty years. Adopted from Korea in 1956, Susan's life experience as an early international adoptee gives her a unique and personal perspective. She has directed Heritage Camps for international adoptees, participated in the Hague Convention on Private International Law in the Netherlands, trained government officials in Australia regarding adoption issues and served as the U.S. spokesperson for Korean adoption. She has consulted with First Lady Hillary Rodham Clinton on public policy regarding adoption and in 1996 was invited to participate in a White House briefing on adoption and foster care for President Bill Clinton.

A nationally recognized presenter on international adoption, Susan has appeared on the NBC "Today Show," "Good Morning America," and in numerous publications.

Marjorie Grace, MSW, LCSW, Diplomate in Clinical Social Work, is a psychotherapist in full-time private practice. She has provided therapy to families and individuals within both public and private agencies since 1974. Marjorie worked for PRIDE Industries (a sheltered workshop), Alta California Regional Center, Oregon State Children's Services Division, and Lilliput Children's Services (a foster / adoption agency). In each of those settings she provided treatment groups and family therapy for families and individuals with developmental disabilities and / or foster and adoption issues. She has focused the last ten years on the effect attachment difficulties have on these populations. In her practice, Marjorie works with adults, parents and children who are experiencing relationship problems due to early parental loss, childhood abuse, and disruption in attachment process. She is the grandmother of a donor insemination child, a member of ATTACh, NASW, Adoptive Families of America, and American Adoption Congress.

Vera Fahlberg, M.D., is a pediatrician who has worked with disturbed children and their families since 1964. Much of Vera's work since 1974 has been focused on attachment and separation problems with special emphasis on children in out-of-home placements. Since 1976, in addition to assess-

ing, treating, and consulting on numerous cases, she has conducted workshops in over 40 states as well as Canada, England, Scotland, Ireland, Sweden, Norway, Greece, Israel, and Australia. She has contributed to a variety of child welfare related training curricula, both written and audiovisual. Her publications include *A Child's Journey Through Placement* published in 1991 by Perspectives Press. She contributed to and editied their 1990 book, *Residential Treatment: A Tapestry of Many Therapies*. In conjunction with Northwest Media of Eugene, Oregon, she completed a series of training videos for caseworkers and foster and adoptive parents. In addition she facilitated a video of adopted teens talking about their experiences. This tape is available from Families Adopting in Response (FAIR) of Palo Alto, CA.

Dee Dee Mascareñas, M.A., M.F.C.T. is a Latina psychotherapist, bicultural and bilingual. She has been a clinician for almost 14 years working with a culturally diverse clientele. The focus of her work has been towards self-empowerment and self-acceptance combining such modalities as cognitive, behavorial, object-relations, existential, humanistic and family systems. She also lectures extensively throughout California on cultural diversity issues, stress management, abuse, etc. She works part-time with El Nido Family Centers, coordinating, developing and implementing a Parenting Enhancement and Counseling Program. Ms. Mascareñas has participated in an extended training sponsored by the Kinship Alliance focusing on Special Needs Adoptions. Ms. Mascareñas is also an adult adoptee who has been in reunion with her biological family.

Joyce Maguire Pavao, Ed.D., L.M.F.T., is the founder and director of both the Adoption Resource Center (ARC) and the Center for Family Connections in Cambridge, Massachusetts (with offices in New York and San Francisco), and the Pre/Post Adoption Consulting Team (PACT) in Somerville, Massachusetts. She is past regional director of the American Adoption Congress. She is an AAMFT Clinical Member and Approved Supervisor. She is also an adopted person.

Kris A. Probasco, LCSW, BCD, is a licensed clinical social worker in Missouri and Kansas. She has practiced in the fields of infertility, reproduction and adoption since 1972. She has worked for both public and private institutions. She is a founding member of Resolve of Kansas City, a community support network for infertility patients. Presently, she serves as a consultant for the Women's Reproductive Center at the University of Kansas Medical Center as well as continuing a private practice. She speaks nationally and locally on various issues relating to her specialty.

Barbara A. Rila, Ph.D., is a psychologist in practice in Dallas, Texas specializing in treating the foster and adopted child, child abuse issues, and attachment issues. She also directs Fostering Progress Inc., an agency licensed to provide therapeutic care for abused and neglected children in the child protective services system.

Dr. Rila presently serves as Chair-Elect of the Treatment Methods Advisory Committee, advising the Texas Department of Mental Health and Mental Retardation and the Texas Legislature on appropriate treatment methods for use with clients.

Dr. Rila has served as the Chair of the Post-Adoption Services Advisory Committee for the Texas Department of Protective and Regulatory Services, and as President of the Board and a Board member of the Association for the Treatment and Training in the Attachment of Children (ATTACh).

Dr. Rila also participates in the work of the Kinship Alliance, and provides training in adoption, attachment, and abuse issues, both state and nationwide. She is often asked to provide consultation, interviews, and information to media representatives with an interest in these areas.

Dr. Rila has two sons and a daughter.

Sharon Kaplan Roszia, B.W.W., M.S. is Program Director of The Kinship Alliance, a recognized expert in adoption as a social worker in the field of adoption since 1963, and an International lecturer. She is co-author of *Cooperative Adoption*, a how to manual detailing the options in creating an open adoption; contributing author to *Working with Older*

Adoptees; co-producer of two videos entitled, *The Seven Core Issues in Adoption* and *Open Adoption: The Experts Speak Out*; co-producer of *Winning at Adoption*, a multimedia package teaching prospective adoptive parents how to adopt ethically. Most recently, she co-authored of *The Open Adoption Experience: A Complete Guide for Adoptive and Birth Families for Making the Decision Through the Child's Growing Years*.

Deborah N. Silverstein, MSW, ACSW, BCD, is a child and family therapist in private practiuce in Newport Beach, CA. In addition, she provides adoption social work services for Kinship Center. She is a recognized expert in the areas of adoption, foster care, and trauma recovery. Deborah lectures and gives workshops on adoption, kinship, abuse, parenting and recovery. She received her undergraduate degree from the University of Pennsylvania in 1967, where she earned a Phi Beta Kappa, and her Masters in Social Work from the University of Southern California in 1981. She is a certified psychotherapist. She and her psychologist husband are the adoptiove parents of four special needs children.

Barbara Tremitiere, Ph.D., ACSW, LCSW, is a social worker who has worked in the field of adoption since 1967, personally participating in over 2,000 placements. Since 1977, she has travelled throughout the U.S. and Canada conducting training and workshops in the areas of adoption preparation, special needs adoptions, transracial adoption, abuse and false-abuse issues, large family adoptions, genetics, and sibling adoptions. She is author of two books: *The Magic of Adoption Success: It's All in the Preparation*, and *The Large Adoptive Family: A Special Kind of Normal*. Barbara also serves as adjunct faculty at three colleges in Pennsylvania. She is the mother of 15 children, now adults, 12 of whom were special needs adoptions. She has 12 grandchildren. Presently, Barbara is an adoption specialist for Tressler Lutheran Services in York, PA.