Observations on the Unique Developmental and Treatment Complexities of Adopted Patients

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ABSTRACT

Contrary to common assumptions, adoption overall is about far more than children and their families. First and foremost, it is about relinquished children who continue to experience repercussions of their adoptive status throughout their lives. They must make profound alternative developmental adjustments that are not experienced by non-adopted people. Regardless of the presenting problems in treatment, and regardless of severity, therapists need specialized skills in history taking, language, differential diagnosis, and in treatment modifications. Most important, therapists should not confuse the mild-to-moderate level of adopted patients' concerns with the serious end of the spectrum that includes attachment, identity, and behavior disorders. The latter usually had experienced early trauma and other adverse circumstances, in many cases resulting in neurological, biochemical (e.g., some major depressions), cognitive processing, and affect-regulation disorders. Regardless, all treatment needs to be skilled in providing psychoeducation based on knowledge of the psychology of adoption. Clinical work needs also to be informed by the psychodynamic and family systems complexities unique to adopted patients of all ages.

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Adoption-informed mental health experts have speculated that adopted people from non-kinship adoptions experience unique developmental challenges that are not experienced by non-adopted people. This paper explains why these complexities warrant an understanding that all non-kinship adopted patients constitute a special-needs population. Competent treatment of the adopted patient requires therapists to make crucial modifications in language, history-taking, differential diagnosis, and in certain treatment procedures themselves.

Specialists also speculate that a relatively small proportion of adopted people are seriously disturbed, usually having a combination of vulnerabilities that place them at even greater risk. Offered here are typical clinical presentations and common treatment problems seen in both out-patient and residential/hospital settings. In this paper, treatment approaches are re-conceptualized as needing a blend of three critical components, i.e., that they be psychoeducationally skilled, psychodynamically informed, and family systems based.

Overall, this article is an attempt to bring more balance to the longstanding emphasis of the adoption field on the adoptive family, generally viewed from the perspective of the adoptive parents of children. Since the 1960's, the adoption field has increasingly incorporated theories of attachment, separation, and early childhood development and trauma. More recently, in response to national efforts toward adoption reform, the adoption field has started to emphasize the dynamics of interrelationships within and between adoptive families and birth families. Except for the fields of social work and marriage and family, the dynamics of family systems are only now becoming more familiar to the counseling and mental health disciplines as they start to grapple with the complexities of adoption's multiple families.

However, as a departure from the virtually exclusive focus on the adoptive family per se, the position taken here is that most fundamentally, adoption is, first and foremost, about the relinquished child who grows up, i.e. the adopted person throughout the life cycle. The adopted person's personality has unique features involving her/his ways of organizing her/his understanding of her/his life and identity as an adopted person. Finally, adoption overall is not primarily about adopted children and their families but, rather, includes the large majority of adopted people who are adolescents and adults. This is when the full impact of being adopted is experienced.

For these reasons, from both clinical and life-cycle perspectives, the psychology of the adopted person needs to be understood on its own terms, as well as within the context of adoptive family life. As one example, the 'nature' part of the nature-nurture riddle becomes clearer over time, demonstrating that many aspects of temperament and personality would remain, regardless of the family in which the adopted person grew up. This becomes particularly evident in late-adolescence and young adulthood when the adopted person becomes increasingly independent of the parents' influence. In no way does this adopted-person-centric perspective diminish the significance of the birthparents ("first parents") or of the adoptive parents and their contributions to the adopted child's development. However, it brings into relief the differences in perspectives in the adoption field. This is evident in the fact that the psychology of the adopted person over the lifespan has come only belatedly to the mental health domain of the adoption field, and not at all to the mental health field as a whole.

Since every adopted person's life circumstances and development, including internal resilience (Masten, A. S., 2014), are unique to her/himself, and since there have been so many recent improvements in adoptive parent education and support, there must also be significant differences in the degree to which the often-cited core issues (Silverstein, D. & Kaplan, S., 1988) in the psychology of the adopted person pertain to each individual. Of critical importance is the need for therapists to distinguish carefully between kinship/nonkinship adoption and closed/open adoption. These distinctions are the crucible in understanding the psychology of the adopted person of any age because, from a therapeutic perspective, the developmental issues throughout the life cycle are very different depending on these variables in adoptive status.

A Theory of Normative Alternate Developmental Adjustment

In discussion of the core issues, it needs to be clarified that most pertain to the proportion of the adopted population that is from nonkinship, closed adoption. Also, further clarification is needed that these are normative adjustments, not pathology meeting any formal criteria, although there is a spectrum of conflict. Also, these adjustments vary greatly in relevance and importance to each adopted person. Throughout their development the adopted person from nonkinship adoption contends, to varying degrees, with the following adjustments:

- loss and, for some, protracted bereavement, sometimes for life vis-à-vis the lost birth relatives; anticipatory anxiety relating to trust, repeated loss, and rejection; for some, struggles with different patterns of attachment (Lyons-Ruth, K., 2003, Ainsworth, M. et al., 2015) or, at a more advanced (or, in some cases, better concealed) level developmentally, with closeness and intimacy in adolescence and adulthood; fluctuations in self-esteem, sometimes accompanied by intermittent or

chronic dysthymia; resurgence of compounded grief upon the death of their parents; for adopted people at mid-life, sometimes sadness around the presumed (second) loss of elderly birthparent(s), even if they are unknown;

- as an extension of loss, struggles with externally-imposed loss of control regarding many components of their lives relating to their identity, for some, extending into difficulties with anxiety and self-confidence, sometimes resulting in a characterological pattern of learned helplessness; most profoundly, for those from closed adoption, the loss of genetically-based information, especially relating to their medical and psychological health throughout life, often resulting in limits to the health care they can receive;

- over time in adulthood, increased concern with genetic vulnerability to such diseases as cancer, bipolar disorder, major depression, schizophrenia, dementia, and congestive heart failure. In the absence of information, all genetically influenced diseases are possible. (N.B., hypersensitivity about vulnerability to disease is reality-based.) For many there is much underlying anger related to their loss of potential access to this information—only because such access is still prohibited by their state government (Bertocci, D., 2014; Pertman, A., 2014);

- for some, particularly older adopted people but more recently also transracially adopted individuals, strong culture-based guilt and shame that may permeate and inhibit their psychosocial and psychosexual development into adulthood. In recent decades this has been greatly mitigated by adoptive parent education;

- identity confusion, including transracial and intercultural complexities; but for those from closed adoptions, also body identity confusion about conception, birth, and human origins. This constitutes a new theory of development that is uniquely and exclusively pertinent to people from nonkinship, closed adoption;

- for many from closed adoption, a sense of lacking an internal compass, confusion in seeking external objects for identification and developmental points of reference; and difficulties envisioning and planning for a future life, which, some have postulated, may be related unconsciously to the unfinished agenda of not knowing their past;

- hypersensitive preoccupations with similarities and differences, engagement in making comparisons that may undermine self-esteem; while at a benign level for some, others do so from a misperceived position of disadvantage and inferiority, sometimes extending into a characterological predisposition toward envious resentment. Although not researched, it could be speculated that the need visually to recognize the face of the biological mother may possibly derive from an instinctive,

internally driven means of finding [a connection with] her, similar to the instinct of separated mother/offspring mammals to find each other by smell. But in the human infant the need visually to recognize and to attach to the mother's face, critical for survival, may have come to take priority, or even replace, the sensory of smell.

- related to this, a persistent craving to experience "looking like somebody"; the lack of mirroring of physical similarities of the family and culture in which they find themselves, especially so for those from transracial adoptions. Also, anxiety about physiological changes, body image over time, sexuality, procreation, and parenting (a sense of being flawed and inadequate, a projected fear of having a "defective" child). For many, the above may finally be relieved, and reach a unique and overwhelming poignancy, at the birth of their first child, when they meet a biological relative for the first time.

All of these constitute normative alternate developmental adjustments in the lives of adopted people from non-kinship closed adoption, usually in combination with each other. For many, they are only of very subtle proportions. But none are experienced by people who are not adopted. Many cited adjustments may also apply to people adopted out of foster care, e.g., loss, including loss of control, shame, and chronic anticipatory anxiety. These intrapsychic burdens vary in their weight while, it is proposed, the adopted person is still able, from outside appearances, to follow the expectable developmental path of her/his non-adopted peers.

It still needs to be recognized that the adopted person typically spends a good deal of additional time and "emotional energy" in these efforts than do their non-adopted peers, especially in adolescence and young adulthood. For at least a few, this may partially account for the concentration and learning problems, and even the developmental delays or arrests with which therapists are familiar. According to anecdotal accounts of adopted adults, these distractions can continue beyond adolescence, and at times interfere in some way with adult relationships, educational achievement, and even employment.

Thus, in the many adjustments that must be made, there are great variations in their significance to each individual; in the flexibility and strength of the individual's internal capacities for making these adjustments, including the patterns of attachment and dis-attachment; in the meaning of the mystery around their genetic template (e.g. their genetically predisposed sensitivities, talents, and vulnerabilities/resiliences of personality and physical health); and late in life, in the meaning and reality of increasing losses and of death, the final separation.

For midlife and elderly adopted people, life transitions are likely intensified by themes of adoption, i.e., loss, separation and abandonment; an increasing sense of lacking control; a struggle to reintegrate residual fragments of their lives and, for many, to make

peace with what they can never know about themselves and their birth families; and the eternal mysteries of death. For some, this will include beliefs in the possibility of finally having a reunion with the birthparents in another dimension. All of the above may continue in varying forms and significance, however subtle, throughout their lives. But for many, *quod te non necat te fortiorum facit*.

The Disturbed Adopted Patient and Utilization of Treatment

One should not wonder, then, about the gravity of difficulties for those with exceptionally adverse life circumstances that precede the adoption but that in some cases may also follow it. The majority of adoptive parents may be at a higher socioeconomic level than the birth family, as speculated, but otherwise are part of the general population with its usual frailties, complexities, and, in some cases, psychopathology.

For the estimated small minority of adopted people whose developmental paths have been derailed, the clinically significant circumstances might begin with prenatal complications such as malnutrition or alcoholism in the birthmother, predisposing to neurocognitive problems; mood dysregulation; problems in language and social skills; premature birth; early postnatal disruptions and protracted trauma, sometimes resulting in bonding and attachment problems beginning in early life; significant learning problems, with particular focus on ADHD, but also of psychogenic origins; bioneurological alterations in the brain attributable to prenatal damage and postnatal severe, early, and protracted trauma (Teicher, et al., 2003; Van der Kolk, 2011); depression and anxiety disorders, in many cases of severe and chronic proportions; confusion and anxiety about sexuality well into adulthood; and the continuing sense of having little control, beginning with the most confusing area of their lives, their adoption.

Despite all of the above, adoption specialists and adopted adults themselves inform us that presently it is extremely difficult for members of the adoption triad to find therapists that are "adoption competent," the term now being used. (This paper uses the term "adoption knowledgeable" because it may be more acceptable to mental health practitioners than the implied opposite, "adoption incompetence".) This pertains in most settings, including private practice, family service agencies, private psychotherapy services, and hospital-affiliated programs in which therapists routinely see adoptive families and adopted children.

The original pioneer to research and publish on the disproportionate number of adopted children being treated in an out-patient child psychiatric facility (15%) was the psychiatrist Marshall D. Schechter (Schechter, 1960). More recently, throughout the country the overall proportion of adopted people needing out-patient mental health services has begun to be researched, now including adolescents as well as younger children, although the methodological problems are significant (Miller, Fan, & Grotevant, 2005). Probably the only means of obtaining more information about disturbed adopted people would be to review

adopted patients in intensive care settings, such as through establishing a data base, as recommended in this paper (see Appendix - even familiarity with this would constitute an excellent training device, each item having clinical significance.) But there is no way of knowing if these are representative of severely disturbed adopted people in the community.

It needs to be studied whether there are differences in the illnesses of adopted patients, depending on whether the care is within RTCs, where referrals may come primarily from the court system or school system, and hospital settings where adopted patients may be more likely to have serious Axis I pathology and to have been admitted by the parents and therapists. Unfortunately, hospitals are likely to provide acute care only. But given the limits of acute care, it also speaks to the advantage at discharge, for many patients in hospitals, of immediate transfer to adoption-knowledgeable residential and intensive out-patient (IOP) programs as they become developed.

The Troubling Lack of Interest Within Intensive Treatment Settings

At the end of the spectrum of the most disturbed adopted patients, reports of the high proportion of adopted children, adolescents, and young adults admitted at random to hospitals and residential treatment programs have thus far been anecdotal, ranging from estimates of 5% to more than 30%. In this light, also remarkable is the fact that hospitals and RTCs have not shown any inclination to examine the significance of this in their own settings. Patients' adoptive status is not a footnote in their early history, but a pervasive and profound aspect of their identity and development over time. Adoption may be indirectly a factor even within acute care, but it is not taken into account in discharge planning because of the lack of adoption knowledgeable psychotherapists in the community. Nevertheless, there is an argument for at least identifying it in preparation for ongoing treatment.

Overall, hospital, RTC, and out-patient services do not reflect what is now understood by many clinicians to be these patients' needs for highly skilled adoption-knowledgeable treatment. It remains to be examined whether, in contrast with many non-adopted people in the community with borderline conditions, some adopted patients may respond to adoption-knowledgeable treatment more rapidly, even leaving the original diagnosis of borderline features in question [see p.13]. Adoption-informed researchers and clinicians (Zamostny et al., 2003; Henderson, 2007; Brodzinsky, 2013) maintain that the mental health field has not recognized that the Psychology of Adoption is an increasingly complex specialty field requiring training (Porch, 2007; Sass & Henderson, 2007; Brodzinsky, D., 2013)), even for the most seasoned clinicians and service directors.

Governmental Neglect of the Adoption System and the Need for Research and Mental Health Services

Statistics about adopted children in the United States have always been very flawed for several reasons, beginning with the lack of awareness of the importance of refining the questions asked, e.g. how "adopted" is defined. The report of the 2010 U. S. Census Bureau states that it has never distinguished among children adopted by stepparents, children adopted by biological relatives, children in non-kinship adoptions, children from "informal" (not legal) adoptions, and adopted children outside the household queried.

Herein lie many problems in studies of adopted children that make statistically-based comparisons of adopted subjects with non-adopted cohorts from the general population. If the focus is on studying the psychology of non-kinship adopted children and adolescents, use of the traditionally cited 2-2.4% proportion of adopted children in the country under 18, relative to the overall population of children, is invalid for making any comparisons. Since the proportion of non-kinship adopted children must be much lower than the census figures of adopted children overall, the significant overrepresentation (5%-30% +) of non-kinship adopted children (if they are accurately determined to be non-kinship) in clinical and residential settings is all the more remarkable.

Of greatest urgency is the failure of state legislatures to allow open adoption to be expedited for foster children. This paper takes the position that this is largely attributable to the tradition of American family law to identify only with the desires of adults and, as in adoption, to regard foster children as "property" of the biological parents. Even when the mothers are chronically and seriously disturbed, and are very unlikely to benefit from "rehabilitation," they are given greater rights than their child. Yet once adoption papers are signed, rights and "ownership" suddenly shift to the adoptive parents (Derdeyn, A. P., 1979). It is important for the mental health field to know that "the best interests of the child" is a concept in their own field and in social services but that, in contrast with other English-speaking countries, in most state jurisdictions in the U.S., it does not actually guide legal practice. This underscores the bias of the American legal system to decide the fate of children, in effect, more according to probate (property) law.

Misconceptions in Mental Health: Understanding the Adoption System and Its Direct Relevance to Patients

Mental health practitioners make many errors in the way they conceptualize and understand adoption, beginning with the general assumption that adoption has little relevance to practice anyway. This is contradicted by experienced therapists' typical acknowledgements, when asked, that they have seen members of adoptive families and adopted patients a number of times over the course of their practices. Therapists generally

believe that they already have sufficient knowledge of adoption and may cite the familiar issues of loss, rejection, attachment, and identity.

However, as complicated as these are, the psychology of the adopted person, particularly from non-kinship closed adoption, is far more complex. Further, without in-depth training (Sass, D. & Henderson, D, 2007; Porch, T. K., 2007), the therapist's understanding is primarily of a cognitive nature. Healing cannot take place without the therapist's own emotional understanding (affective engagement), i.e. without her/his authentic empathy with the adopted patient's inner experience over time. A full knowledge of the questions that need to be asked at appropriate times is an essential means of expressing understanding and empathy, and of strengthening engagement in treatment. Examples would be details about body image and health concerns (especially genetic questions); how and when they were informed of their adoption, and how this was experienced over time; confusion about personality characteristics and interests and "where they came from;" fantasies about the birth family. The above pertains to all out-patient treatment of adopted patients, including private practice, as well as to intensive treatment within hospitals, RTCs, and IOPs.

The following are corrections to many therapists' misconceptions about adoption, misunderstandings that inevitably interfere with the therapeutic and empathic process:

(1) Only some adoptions have followed lengthy and disruptive foster care placements, although this is increasingly so. Nevertheless, adoption overall is not about foster care. This does not seem to be understood when some agencies offer counseling services to adopted youth that are provided by professionals whose experience has been virtually entirely in home studies and foster care. In other words, they are unaware of the need for more in-depth understanding of the psychology of the adopted person.

(2) In many cases, adoption involves early postnatal developmental trauma, while possible damage to multiple prenatal bioneurological systems, such as in the case of fetal alcohol syndrome, may be given insufficient consideration. Further, relatively few psychotherapists are trained in this area, or understand the need to include it in a clinical assessment in order to make the most comprehensive and appropriate treatment plan.

(3) Studies and treatment services have been based almost exclusively on attachment theory, particularly in the U.K., while little consideration has been given to post-'early childhood' (above age 5) for those that do not have attachment disorders. For example, one would expect a higher level of ego functioning under stress despite the fact that the adopted person may still struggle with separation anxiety, chronic anxiety about potential rejection, intermittent mood dysphoria, and various forms of social and performance anxiety. Because of the field's nearly exclusive emphasis on attachment, many patients with much higher

levels of emotional and social functioning have not been given adequate focus or consideration.

(4) Non-kinship adoption overall may or may not be about prenatal damage or early developmental trauma, but it is always about loss and identity, as well-documented over the decades in the literature (Brodzinsky & Schechter, 1990; Brodzinsky & Palacios, 2005; Bonovitz, 2006; Javier et al., 2007; Grotevant, 2011). These may or may not become life-long struggles, depending largely on the significance of any early and serious trauma, on the degree to which the experience within the adoptive family has contributed to a process of healing and growth, and, above all else, on the adopted person's inner resilience.

(5) In order to develop empathic engagement in treatment, it is important for therapists to learn the language of adoption, i.e. language that is sensitive to the adopted patient's perceptions and emotional experience rather than common culture-based distortions and misunderstandings. This begins with the following: The child was "placed" for adoption, not "put up for adoption" (suggesting an auction). The birthparents are the first parents, but they are not the "real" parents since "real" refers to the psychological parents. Because of the profundity of the psychological issues, the adopted person's wish to have information about the birthparents, or to meet them, is never out of "curiosity," a term that trivializes the adopted person's need since all that is being sought is identity-related. An adopted person may use the term "curiosity" themselves ("I'm wondering") but they too are unaware of the profundity of their underlying needs; a benign term helps contain the turmoil. Rather, they experience a craving to understand, and to be understood, at both cognitive and emotional levels.

A therapist's questions such as "what about your parents?" implies the patient's lack of concern for others' feelings. From information gathered anecdotally, it is almost always the reverse. The typical question of therapists "when were you adopted?" is a legal question, whereas the developmentally relevant question is "when did you join your adoptive family, and what do you know about your circumstances before you joined them?"

(6) The majority of adopted people in the United States, now adolescents and adults of all ages, have been from closed adoptions. It is essential that psychotherapists understand the distinction between closed adoption and open adoption, and their respective impacts on psychological development. Open adoption (McRoy, R.G., et al., 2007), practiced since the 1980s, is a mutual arrangement between agency, adoptive parents, and birthparents, that pre-specified information and/or contact is made available at an agreed upon level and frequency. The child may or may not know the identities of the birthparents. If the child later wishes information (e.g., medical history) and the birthparents are inaccessible, the record itself may be closed, depending on the state.

By contrast, closed adoption was insisted upon by adoption workers and social workers over three generations ago, based on several untested theories of postplacement adjustment of both the child and the birthmother. In the 1930's and 1940's closed adoption had the common practice of keeping babies in foster care in order, many months later, to test their intelligence. In some cases babies were shifted through multiple foster placements so that their only attachments would be, eventually, to the adoptive parents. There was a long lag in time before attachment theory prompted the adoption field to place children earlier than one year. This 'dark secret' is unknown to current generations of adoption professionals and does not appear in the published histories of adoption.

Despite all that has become known about children's development over time, the adoption record is still sealed into law by over two-thirds of the states*, continuing to bar adopted adults from having access to their own (original) birth certificates. This has been partly justified for providing birthmothers privacy, but there is no evidence that confidentiality was ever defined or explained to them. In one study, birthmothers stated that at the time they relinquished their child, they never intended confidentiality from the child her/himself (Pertman, 2011). The primary legal and sociopolitical agenda, however, was in effect the sealing of the adoptive parents' ownership of the child, assuring that they would be legally protected from threat, particularly from birthmothers.

If an adopted patient reveals a wish for their original birth certificate, its significance is that it represents the reality and meaning of the biological tie to the birthparents, the profundity of the need for a direct biological (= human) connection, and the potential for finding them for validation. There are many reasons for the fantasy of finding the birthparents, including, at a conscious level, the need for genetic and medical information (Schechter, M.D. & Bertocci, D., 1990; Bertocci, D. & Schechter, M.D., 1991; Triseliotis, J. et al., 2005). Advocates for the open record point out that the only other group ever denied birth certificates were the American slaves, property of their owners. The adopted person's search for information about the birth family, or to have a direct meeting with birth parents or other members of the birth family, constitutes their attempt directly to face and adjust to the real circumstances of their lives so that their development as a full person is no longer blocked, as they experience it. There is no evidence to support statements, including from members of the mental health field, that "many searches do not end well."

(7) There is a hidden dark side to adoption that likely relates to the fact that adoptive placements, usually through public welfare, have been handled by workers lacking skills in the selection of people wishing to adopt. More recently, this also relates to the fact that so many American attorneys, few having specialized training, are handling independent adoptions, for the most part viewing their role as solely a legal exercise (through identification with the parents), while there is usually no protocol for record keeping and no

screening of the potential. Generally, the rare outcome studies are usually from the perspective of the adoptive parents.

Overall, the impact on many adopted people has been profound, e.g. growing up with parents with attachment problems and empathic deficits, parents who had narcissistic reasons for adopting, and parents with impairments (e.g., alcoholism) prevalent in the general population. There is also, as reported to therapists, the possibly disproportionate number of adopted people who have experienced incest within their adoptive families, the lack of a biological tie being used to justify it. One could speculate that, in combination with other vulnerabilities, what is being referred to here as the dark side of adoption may account for some proportion of the cases involving major depression and suicidal preoccupation or attempts. Regardless, it is important for the therapist to listen for these issues, and to know the questions to ask at the appropriate time.

It needs to be remembered that the more recent changes and improvements in many areas of adoption overall, such as the various levels of open adoption and the more recently available support services, have in fact eclipsed the ongoing complex needs of the large majority of non-kinship adopted people, those from closed adoptions, who have never been able to benefit from them.

A Re-Conceptualization of the Needs in Treatment

Orientations of specialists and programs vary, and there is undoubtedly disagreement about how a comprehensive service could be defined. In the Adoption-Based Comprehensive (AB-C) model proposed here, admittedly ambitious, a comprehensive program would involve three integrated components making it psychoeducationally structured (similar to CBT approaches as currently used, but adoption knowledgeable), psychodynamically informed, and family-systems based in the overall conception of both programming and treatment.

Above all else, the most crucial aspect of any treatment is that the therapist be able to convey to the adopted patient that he/she is understood, especially empathically. This requires an emotional, as well as intellectual, understanding of the adopted patient, i.e., the music as well as the words. A full knowledge of the questions that need to be asked at appropriate times is an essential means of expressing empathy and of strengthening engagement in treatment. The above pertains to all out-patient treatment of adopted patients, including private practice, as well as to intensive treatment.

As a critically important disclaimer, in no way does the psychology of the adopted person imply that adoptive status per se is usually the overriding determinant of the psychological disturbances in adopted patients. However, it needs to be understood in order to be placed in perspective in the overall clinical picture. The great need now is for the mental

health field to come to understand that all adopted patients constitute a special-needs population entitled to the care of adoption-knowledgeable professionals, along with the necessary financial and institutional support.

The Foundation of the Psychoeducational Component

Particularly in residential treatment programs, this component, typically modeled after the familiar cognitive-behavioral format, is the primary venue currently in practice, emphasizing intervention and behavioral modification within the context of groups, and focused on learning new, more effective life skills and on changing self-defeating behaviors. This is considered to be the modality of choice because so many of their patients/residents need to learn to control their impulsivity and anger, to learn the impact of their "acting-out" behavior on others and on themselves, and, of greatest importance, to learn that other people can care about them with consistency, and support them in their efforts to face painful emotions.

Adolescents and young adults who have already had treatment experiences have typically been through a number of generic cognitive-behavioral treatment (CBT) and dialectical behavior treatment (DBT) programs prior to hospitalization or RTC care. In these cases little is likely to be accomplished by repeating them when the patient/resident goes home unless they understand the relevance of the patient's adoptive status. The psychoeducational component is already well established, so it is not necessary to expand upon it here.

The Importance of the Psychodynamic Framework

The psychodynamic orientation in psychotherapy differs from that of the traditional cognitive-behavioral approaches of most intensive treatment programs which emphasize learning (cognitive/intellectual understandings). Disagreements about the psychodynamic perspective are usually based on misunderstandings of its meaning and use, such as the assumption that it pertains primarily to long term, less interactive psychotherapy. There is a difference between being psychodynamically informed and, on the other hand, utilizing the treatment approach for which the counselor or therapist is trained, such as utilization of psychoeducational approaches.

Presently most mental health disciplines understand that all good therapy acknowledges strengths, is guided by the client's goals, and understands, at least at a conscious level, the relationship between past experiences and current concerns. However psychodynamically oriented therapists understand that emotions are by definition dynamic, i.e., fluctuate, and are influenced by perceptions and different levels and defenses of the personality. The psychodynamic perspective works at a deeper level with emotions and fantasy (i.e., all that the adopted person imagines and feels), all having unconscious roots

(Bonovitz, 2006). These readily inform the therapist from the beginning of treatment, as well as over time.

The following are clinical profiles of many disturbed adopted patients who, if motivated to get well and if able to engage in self-reflection, can benefit from a psychodynamic, as well as psychoeducational/cognitive base. These include pervasive, underlying anger (much that conceals anxiety) displaced onto the adoptive parents, with which parents also need help; for some, a pattern of manipulation, stealing, and lying (N.B., all of which have been elements in the adoption field itself); a history of running away (abandoning); symbolic (unconscious) searches for what was lost (e.g. sleepwalking); a chronic sense of vague generalized confusion; psychogenic as well as neurologically based learning problems (e.g., fear of knowing); frustration intolerance and difficulties with anger management; co-morbidity of anxiety, depression, and substance abuse; dissociative disorders related to trauma; and sexual acting-out, e.g. pregnancy in adopted females, with unconscious motives related to both mothers.

For some there is also confusion around gender identity, and there are reported gender differences in how adopted adolescents experience adoption (Freeark, 2005). These include girls' unconscious and anxious identification with the adoptive mother's infertility, if relevant, and the mutual dynamics relating to the adoptive mother's unconscious envy of the daughter's reproductive capability; boys' identification with negatively-represented or imagined birthfathers, the suspected high proportion of adopted males with anxiety (e.g., fear of rejection) and/or unconscious anger toward women (difficulty understanding and empathizing with the plight of the birthmother); for both males and females, confusion and compromised judgment in choices of peer and intimate relationships, particularly when anxious about dating or marrying a biological relative. Although this has, in fact, occurred, the psychological issue is the anxiety: From the perspective of the adopted person, what cannot be ruled out is always possible.

For perspective, for many healthy adopted adolescents as well, particularly those from closed adoption, there is typically enormous anxiety and confusion around the usual physical changes in adolescence that may cause, for some, a terrifying "experience of alienation" (Dalley, T. & Kohon, V., 2008). As some adopted people have commented, the feelings would be expressed as: "I don't know what's happening to my body, where it came from, or where it's going." There may also be confusion, at least at the unconscious level, about conception and birth. For some adolescents and adults there may be sensitivity about the parents' feelings, and therefore ambivalence about "celebrating" birthdays. For adolescents from non-kinship closed adoption there is no biological or psychological frame of reference. This results in a form of body image and personality confusion not known to the non-adopted population. Adopted adolescents and young adults from closed adoption

must sail uncharted waters into and throughout adulthood with neither a compass nor a rudder.

Although not researched, there appear to be some gender differences in fantasies and activation of search for the birthparents. It is speculated that adopted females are more likely to be able to identify with the birthmother's conflict; at a conscious level some adopted males have stated that they are more interested in finding their birthfathers, or in finding the birthparent who "cares the most" (i.e., did not really "reject" them). Along with this is the riddle of how to individuate (the gradual, age-appropriate dis-attachment from the parents) when there is so much unresolved attachment and/or separation anxiety. It becomes all the more complex when it is one or both of the adoptive parents, and not the adopted child, that have empathic deficits, attachment disorders, or narcissistic pathology, i.e., problems that are far more serious than the "poor fit" of differing temperaments generally mentioned in the social work field.

A maladaptive solution for many adopted adolescents is to develop intense, pathological attachments to "safe" love relationships with equally vulnerable people who, from a psychodynamic perspective, serve as transitional objects. However this is at the considerable expense of age-appropriate developmental progress. For the more fragile, the eventual breakup of these relationships can be heavily loaded with themes of loss and abandonment that may result in acute separation anxiety, ego-paralysis, anxiety/panic states, and descent into severe immobilizing depression, including suicidal thoughts (Festinger & Jaccard, 2012) or intentions and actual suicide attempts (Slap, 2001; Keyes et al. 2013). Suicide represents the ultimate control a troubled adopted individual can finally have over her/his life, by ending it (see Postscript).

The Adoption-Based Comprehensive (A-B-C) model hypothesizes that the psychodynamic component is needed in short term programs as much as in longer-term programs, in fact probably more so. However further study of this is needed. This paper agrees with psychodynamically informed clinicians that acquiring this foundation requires extensive advanced post-degree training followed by credentialing, not only as a psychotherapist but as a clinician. This view also holds that the disadvantage of trainees, aside from the limits in their knowledge and life experience, is that they must work within a particular time frame, inevitably resulting in separation and in the adopted patient's internal experience of another abandonment. Since the perspective of this paper is that psychodynamically trained therapists are able to "listen faster," their ready understanding at multiple levels serves to speed, not protract, the recovery process. At least the adoption knowledgeable therapist can raise the awareness of certain issues that the patient may want to address at more length in treatment after discharge. It is understood, however, that perhaps especially in RTC settings, where the emotional damage tends to be severe, there are great variations in patients' capacities gradually to contain externalizing defenses (acting-out) and

to develop more internal awareness of the connection between their adoptive status and their relationship and behavior difficulties.

The Importance of the Family Systems Framework

Family systems theory, one of the hallmarks of social work, emphasizes the interconnectedness and interdependence of family members in the complex emotional life of the family as a unit. The family systems approach to treatment of adoptive families attempts to blend adoption-related issues with the traditional approach with non-adoptive families (Reitz, M. & Watson, K., 1992). Adoption of a child inevitably means changes in the dynamics of the marriage, certainly also when there are other children in the family. But among other considerations, the traditional family systems model assumes that family members know who each other are.

In comparison with non-adoptive families, the non-kinship adopted person has four parents, two of whom are ghosts (if closed adoption), birthfathers being the most overlooked and misunderstood population (Clapton, G. (2003). Regardless of whether family members have conscious thoughts about it, the adoptive family is in fact three or more interconnected families, although members do not likely know the identities of all other members. This probably would not be the case when the adoption has followed foster care, involving direct contact with one or both birthparents.

For those who do know each other, as in the case within the adoptive family, there are both similar and very different emotional dynamics from the traditional family. If one adds to this a psychodynamic understanding of the role of fantasy (fantasied relationships) in the minds of each family member, as pertains in all adoptive and birth families, the double or triple-complexity of the adoptive family becomes more evident.

But how is the "interconnectedness" of family life to be understood when a traumatized child or adolescent has experienced many disruptions, separation-attachment problems, and other serious developmental difficulties? How can an internal sense of family cohesion and protection be developed when loss, a sense of betrayal, and secrets pervade the thinking and emotions of many adopted people? And how is this possible when two of the families, those of the birthparents, are unknown – and presumed (probably incorrectly, based on the available feedback from birthparents) not to care? The adoptive family includes missing and fantasied family members who must be acknowledged therapeutically as part of the adopted person's family system. Unless family systems-based practitioners are also knowledgeable about this, they are not likely to take this into account in their family treatment.

The emphasis in the A-B-C model is on the adopted patient's perception of these interrelationships, along with those of the adoptive parents. The family systems perspective tells us that, as a means of helping the adopted child and adolescent integrate their fragmented

experiences, in most cases their treatment is best conducted with the active involvement of the adoptive parents and, often, of siblings and other relatives, sometimes including foster parents (Grotevant, H. D. & McRoy, R. G., 1990). Finally, it understands that all adoption is intergenerational, impacting the adopted person's own children and, sometimes in turn, their grandchildren.

A Critique of the Adoption Literature

Although there is a good deal of literature reporting various studies of adopted children, comparative studies are greatly handicapped by the flaws in the available statistics and, in some cases, by research procedures that do not make the necessary distinctions about the adopted children being studied (e.g., kinship/non-kinship, closed/open adoption). This brings into relief the importance of researchers and psychotherapists being very careful to understand the many complex facets of adoption and to define the terms, methodology, and subjects that they use in the course of their work. For example, a sample of adopted subjects recruited through adoptive parents' groups is already a biased cohort and cannot be used to generalize about the overall population of adopted people.

In the adoption literature generally, much of which does not depend on statistical data, many works are by individuals who are acknowledged experts in the adoption field overall (Pavao, 2005; Pertman, 2011). Many are excellent edited books with chapters written by specialists and experts covering a wide range of topics (Brodzinsky & Schechter, Eds.,1990; Groza & Rosenberg, Eds., 2001; Brodzinsky & Palacios, Eds., 2005; Hushion et al., Eds, 2006; Javier et al., Eds., 2007). There are also many journal articles on specific topics, such as the lack of awareness about adoption in the counseling field (Zamostny et al., 2003), gender differences and the life cycle (Freeark, et al., 2005), and suicidal risk in adopted adolescents (Festinger & Jaccard, 2012). As in the case of the latter, however, one problem has to do with research on clinical issues that lack the necessary refinements in order to make the results most meaningful.

Over the years there has been a substantial interdisciplinary literature, including some research, on such topics as the impact of various forms of openness in adoption; adoption of special-needs children; the differences between children placed early and those placed after age two; cross-cultural and transracial adoptions; adoption of international children; and adoptions within non-traditional families, all reviewed by authors in Javier et al., 2007. In both the U.S. and the U. K., publications of psychoanalysts tend to be primarily discussions of individual adopted patients who were in treatment with them, usually children and adolescents, to illustrate the complexity of clinical issues (Hushion et al., Eds.; 2006; Deeg, 2007; Hindle, D. & Shulman, G., Eds., 2008).

Regardless of the disciplines of therapists who have published in adoption, we learn from all the literature that, as complicated as life adjustments and internal struggles are for all

patients in therapy, they are magnified incalculably for those from a combination of non-kinship and closed adoption. As a generalization, the small amount of literature addressing treatment considerations suffers from the lack of substantiation or modification through research, and we are left with an extensive catalogue of observations, anecdotes, and speculation. This certainly poses a problem for "evidence based" programs, particularly those that are cognitively-oriented and limited to meeting arbitrary criteria (Shedler, 2015). There are probably few areas of the mental health field that have greater need for formal research than the psychology of adoption, although research about the adopted person will continue to have great difficulty finding "representative" subjects.

Common Clinical Presentations and Common Treatment Problems

There is limited recent (i.e., since 2005) adoption literature with either a research or clinical focus, and relatively few publications that mention the inner life of the adopted person throughout the life-cycle (McGinn, M., 2007; Rosenberg, E., 1992). Even then, the "life-cycle" essentially ends with young adulthood. For this reason, much-needed advanced clinical research and more evidence-based information is yet to come. In the meantime, the following are additional common clinical presentations, but also common treatment problems, that begin with the therapist's need to know the many necessary questions to ask.

If it is adequately explored, therapists might hear about psychogenic learning inhibitions and difficulty concentrating; difficulty controlling anger generally, displaced anger or ambivalence toward the parents (but also a key feature of adolescence generally); a longstanding feeling of "having been gotten rid of" or of "not fitting in"; difficulty making certain kinds of decisions (e.g., a sense of "floating through space and never being able to land"); difficulty disengaging from poor relationships out of hypersensitivity to the impact of rejection on the other person; similarly, a guilty pattern of seeing therapists whom they say did not seem very helpful ("my adoption came up once or twice") which may be associated with concerns about "fit"); confusion about choices in love relationships; at times, a longstanding vague sense of sadness without knowing why.

Although there are no studies of the readiness with which adopted patients are able to engage in treatment, it could be assumed that it is likely to be especially difficult for patients with anxiety about rejection, attachment, separation, loss, and dependency. For them the exploration of adoption-related areas may be threatening, and timing becomes an important issue in the initial phase of treatment. Of the adopted patients likely to seek out-patient psychotherapy, including even the healthier population, defense mechanisms may include denial and avoidance (warding off pain and rejection); vacillating idealization vs. denigration (splitting) of people in their lives (half of whom are missing, resulting in some adopted people feeling that they are leading "split lives" – the reality being that they are); projection, e.g., confusion about who "rejected" whom; projective identification, e.g., the mutual transmission between parent and child of trauma, shame, and attachment ambivalence

(Bonovitz, 2006); and displacement of anger and mistrust in the form of blaming the parents and/or the therapist, e.g., impulsive (re-enacted) abandonment of the treatment/therapist, or in acting-out behaviors. Therapists have reported anecdotally that sometimes they have a sense of their adopted patient (undoubtedly from non-kinship adoption) as seeming like a "lost child."

In treating the more disturbed adopted patients, such as in IOP and RTC settings, therapists will encounter themes that are similar to the healthier adopted patients, but many times more acute, severe, and chronic, perhaps at times seeming intractable. In the absence of in-depth and systematic research with a clinical component, the above material is necessarily anecdotal, based primarily on therapists' informal reports of their work with adopted patients, and on the revelations and autobiographical publications of adopted adults, some of whom are counselors and therapists themselves.

It is speculated that severely traumatized non-adopted patients using the defenses referred to above, have sometimes been misdiagnosed as "borderline" when in fact the symptoms and defenses over time are commonly found in severe trauma victims, such as patients who experienced protracted sexual abuse. But unlike non-adopted trauma survivors, adopted patients will make such references as "I don't know who I really am, or even what I look like. I look in the mirror and see just a blank face." Or, "sometimes I think I must be from another planet." This is typical language of some adopted adolescents and adults, often those who are in the healthy group of adopted people, and is not a feature of borderline psychopathology. Although there may be additional borderline-sounding features, such as confused identity, pronounced affect instability, and impaired interpersonal relationships, the combination of resilience and capacity for insight means that many can be treated at a faster pace (because they are not true borderlines), with anecdotally reported positive outcomes.

Most important, funding issues need to be considered separately from the question of whether intensive treatment programs are sufficiently sensitized about their adopted patients to consider developing specialized services for them. Much can be accomplished through in-service training, without additional formal funding. Regardless of the length of stay, administrators interested in developing an adoption-knowledgeable intensive treatment program, perhaps within the general program, might consider the following:

Proposed Criteria for Specialized Program Development

1. Length of stay: preferably a minimum of 3 weeks to two or more months.

2. Regardless of the length of stay, establishment of a data base for further study.

3. Core adoption-trained interdisciplinary clinical staff with use of consultants. For RTCs affiliated with hospitals, psychiatric evaluation and psychopharmacological management on site; access to neuropsychiatric/ neuropsychological evaluation,

psychological testing (both cognitive and projective); specialists in ADD/ADHD, PTSD and neurobiology of trauma (Teicher, et al., 2003); psychosomatic medicine (e.g., gastrointestinal disorders); sexual trauma; eating/nutritional disorders (Holden, N. L., 1991); and genetically-complicated disorders.

4. Specialized skill in differential diagnosis: Primary diagnosis for many would likely be PTSD, sub-type Complex Trauma Disorder (Van Der Kolk, 2011), and other Axis I disorders. In the case of older adopted adolescents and young adults, and certainly of adults generally, Axis II would be included, as appropriate.

5. Understanding of the "language of adoption" (see p. 9) Understanding the developmental impact and age of placement, including history of foster or institutional care, whether closed or open adoption; the significance of "the telling" process and of the adopted child's interpretation of it; history of early deprivation, trauma, and of any neurological and medical complications; interracial and intercultural adoptions; the meanings of the adopted person's fantasied or activated search and, if deemed clinically necessary for adolescents under 18, determining criteria for supporting exceptions to state law so that the adoption record can be unsealed for younger adolescents.

6. For those that appear to have attachment disorders, understanding the different patterns of attachment problems. The adopted person's often-referenced conflicts around intimacy may not be based on attachment problems but more representative of difficulties found in the general population.

7. Group treatment would be informed by, but not entirely based on, traditional DBT or CBT models that are easily available in the community except that they are not adoption-informed. Recommended would be group therapy based on the three components of the AB-C model, just for the adopted patients, if there are sufficient numbers.

8. Individual treatment equal in value to the other modalities. In out-patient settings, psychotherapy would best be rendered by experienced therapists who can make a commitment to provide open-ended (long-term) treatment, i.e., sparing the patient more transition and loss (the considerable disadvantage of most trainees). The family therapy portion of the treatment plan could be an important training experience for students in social work, counseling, and marriage and family therapy.

9. Inclusion of specialized therapies and programs, not only as a means of expressing repressed, depressed, anxious, and angry feelings, but of experiencing acceptance and understanding, forming warm attachments, and consolidating identity. For longer stays, recommended would be ethnicity-specific programming (e.g. Latino, Asian, Eastern-European, Russian, African, etc.).

10. Intermittent follow-up studies of each patient, with reports of findings that could potentially become part of research efforts, contributing to best practices.

It is the author's view that incorporating the above, in whole or in part, would begin to demonstrate best practices that are so long overdue in all mental health settings.

Summary

The position taken here is that adoption overall is, first and foremost, about the relinquished child who grows up, i.e. the adopted person throughout the life-cycle. Under the best of circumstances, the adopted person contends with alternate, compounded, and often difficult developmental tasks that are normative for the adopted population, particularly those from closed/non-kinship adoptions, but unknown to the non-adopted population. It is proposed, although research is greatly needed, that it is the cumulative effect of adverse conditions that may account for the subgroup of adopted people who are seriously emotionally disturbed and mentally ill.

Presently, even when hospitals, IOPs, and other intensive treatment programs are aware that many of their patients or residents are adopted, their programs and services do not reflect what is now believed to be these patients' specialized needs therapeutically, and often they involve more developmentally advanced difficulties than attachment disorders. Emphasized here is that therapists need to understand the importance of distinguishing between closed and open adoption, between kinship and non-kinship adoption, and their very different impacts developmentally and psychologically.

Conclusion

Adoption specialists have learned that, from the perspective of the adopted person, (note the absence in this article of the depersonalizing term "adoptee"), the psychology of the adopted person is about their craving not only to feel safety and permanence, to feel loved and understood, and to have a firm sense of belonging and of being wanted. Most profoundly, for non-kinship adopted people from closed adoptions, the great majority statistically at the present time, at a much deeper level for many, the psychology of adoption is about their craving to understand, to feel understood, and to feel a connectedness to the human family. Overall, as a concise sociopolitical statement, adopted patients of all ages needing treatment should not be left to feel abandoned again, this time by the mental health field itself.

Postscript: This paper is dedicated to the memory of Carla, born half-Japanese in 1946. Her placement through a well-known child welfare agency was delayed by years of foster care because of her mixed-race. She was eventually adopted under "last resort" circumstances, which over time left her with additional emotional scars. Throughout her adolescence and young adulthood she saw many therapists, including a prominent psychiatrist, for adoption-related depression, but stated that none of them really understood or helped her. Carla's exotic beauty, intelligence, and sense of humor endeared her to her many good friends (including the author), but this belied her secret despair and, in her forties, she took her own life.

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Author's Note: The history of the adoption field in the U.S. since the 1930s has been the domain primarily of welfare departments and of social work, both dedicated to the placement of children in need of permanent homes. Over the decades these services were usually provided under the most difficult conditions by workers who often lacked professional credentials, struggled with enormous caseloads, had inadequate training in child development, marginal compensation, and little governmental or public support. Even now, welfare departments are often staffed by workers lacking sufficient training, the relatively few professional social workers providing only supervision. Professional social workers have been more usually hired by adoption agencies.

Also, over time, professional social work developed substantial clinical specialties, some of which have been subsequently credited to other mental health disciplines. These include focused short term treatment, treatment of families based on an understanding of family dynamics and intergenerational systems, domestic violence, sexual abuse, psychoeducation (a primary feature of "cognitive behavioral"), and interview technique. For the most part, research in social work has been, in effect, a poorly funded luxury.

No effort can "make up for" the past inadequacies, unwarranted biases, and outright mishandling of welfare and social work in many areas of adoption. Indeed, these still pertain in some settings. However, regardless of whether there is agreement with the author's viewpoint and re-conceptualization of clinical issues, it is time that professional social work took some leadership and responsibility in adoption reform and in ensuring higher standards throughout the adoption field. It is also an opportunity for clinical social work to take

leadership in exploring more fully the clinical and treatment complexities, particularly in the psychology of the adopted person over the life span. Although past errors cannot be undone, there is much that social work and clinical social work can do now to collaborate with other fields, to conduct sophisticated research, and to train the mental health field. Tragically, the missing field in efforts to ensure the "best interests of children," including adopted children who grow up, is family law. DB

Appendix: Database*

Name of hospital/RTC & Location:

Any specializations Educational component?

Average length of stay

Number of patients/residents Ages served Gender F M Coed

Percentage of adopted patients at any one time (estimate)

Case ID Age/yr. of birth Home state Ethnicity

Preliminaries of the adoption: Place of birth

Circumstances of relinquishment for adoption

Any contact with birthparents and at what ages

Adoption status: non-kinship kinship domestic international/country

Open Closed

Source of placement: welfare/public private agency attorney other (specify)

Circumstances prior to adoptive placement: Care within biological family institution/agency

History of foster care: ages number of foster placements impact developmentally

Age when entered adoptive home

Developmental information

Month/yr. of admission Length of stay Reason for admission

Referral source

Medical history

Psychiatric/treatment history

Mental status

Primary and secondary diagnoses on discharge

Involvement/treatment of family during stay

Discharge plans

Relevance of adoptive status to diagnosis, reason for admission, course of treatment

Family's concerns regarding future adjustment/behavioral/mood problems

Is patient/resident agreeable to being contacted for an outcome study? Release?

*Each institution would determine its own protocol for collection and use of this data