PSYCHOSOCIAL DEVELOPMENT OF ADOPTED CHILDREN

by Geoffrey A. Rickarby FRANZCP

ABSTRACT

This paper develops the earlier work of the author and his colleagues, with the hindsight of a further twenty years of caring for disturbed adopted children.
It examines the themes of attachment/detachment, trust/distrust, gratitude, obligation and belonging, major difficulty in identity formation, response to obfuscated adoption motivation and high levels of conditioning and control that are the lot of those adopted children who are fortunate to be brought up in a family where they can remain until at least middle adolescence.

An Eriksonian model is used, and the work of Stierlin is drawn upon in understanding psychosocial separation issues of late adolescence. The thesis is put forward that adoptive children have more difficult and less culturally supported developmental tasks to achieve than those in a moderately functioning biologically related family. It puts a plea for more education of adoptive parents in these special difficulties, as they also suffer severely as a result of ignorance of these mostly inevitable processes.

PSYCHOSOCIAL DEVELOPMENT OF ADOPTED CHILDREN

Introduction.

Erikson's model of human development is *epigenetic*. This is to say that each stage of psychosocial development is built upon the previous stage or stages of development and their outcome. For example a child who has a significant sense of **basic trust**, will seek **autonomy** and test it behaviourally without readily falling into **shame and doubt**. Or obversely a child with poor resolution of shame and doubt issues will have more trouble developing **initiative** unclouded by excessive **guilt.**
These earlier developmental stages form a developmental pattern at the same time as the child's primary school education is beginning the serious years of acquiring literacy and adapting to the whole theme of continuing education.

In an adoptive family the child has nearly always been told he or she is adopted, often long before the conceptual notion of the word is within his range. In an adoptive family with a successful marriage with mutual motivation to adopt - as well as the capacity to grieve their infertility, and assuming the absence of mental illness including alcoholism, the child has adapted to their new parents' idiosyncrasies sufficiently to have arrived at this stage of development with their own pattern of function. Note, that for the purposes of this paper, we are talking about those adoptive families still functioning as a family.

To Erikson, Primary School is the time of development where the maturing nervous system and psyche is being shaped by education, nurture and activities. He sees the time as one where the development is one of **industry** and the psychosocial alternative is a feeling of **inferiority.**

In common speech the issue of these years is, "Am I an okay kid?"
Not only must he or she be 'okay' in parent's eyes, but now the teachers and peer group are becoming more and more important.

Working at education and development is always to the standards of the family where they are brought up, and the school chosen. This is one place where the fit between adoptive parents and child does matter. Biological parents readily recognise their own behaviours and temperament in their children, which might lead to compassion or even over-reaction at

elements of themselves they accept. Adoptive parents are, with good reason, often bewildered. The child has different abilities and interests than they had, they seem to relate to other children in a manner that is unfamiliar; their spontaneous reactions to shock or frustration seem strange. At this stage the child is being tested hard by his social field. When he goes home and relates this, he or she needs every bit of validation by mirroring in hearing, "You're okay.", that is available.

It is from being an okay child with a sense of self that the adolescent finds his or her identity. Identity in our culture is an underrated issue for the reason that those who have an identity arising from a greater family background and strong sense of self take it for granted. They don't know what it is like to struggle for an identity. Those who don't have one, are depressed, lack direction, are distracted by substance abuse, settle for destructive relationships and stop trying.

In the greater family there is nearly always significant contact with other children, most commonly cousins. Cousins are a common source of information, some of it wrong or distorted. The material has its origins in the aunts and uncles' discussions about the circumstances of the adoption, and snippets of gossip or speculation about the original mother and father of the boy or girl. A child who is not informed derives information readily from other children; cousins are a frequent source; many crises may occur from wrong information, sometimes far-fetched, and even information that is roughly correct.

For an adoptive child one alternative to this is no information whatsoever, a total wall of silence about his or her origins. Some adoptive parents provide information that is fed to them by agencies to be used at the appropriate age. Often this is edited, distorted or simply not factual, even the result of communication mistakes.

Anglo-Saxon and European culture has a background of centuries of successful breeding techniques long before it received help from science or the discipline of genetic research. Every family has its myths of who took after whom, and what the family was noted for in abilities, character and appearance. It is hard for an adoptive child to *"…know what I am really like."* Other difficult notions are there for the child, such as *"had to give you up for adoption.",* and *"we chose you."* The culture doesn't help the adoptive family either, because common culture says, *"It will be just as if you had your own children."* The family are let down by not being supported by the culture in which they are supposed to exist as if adoption had had not occurred.. Confusion and insecurity readily occurs, particularly if one of Erikson's first three stages has left some mistrust, shame, doubt or guilt as a problem for the child.

There is **insecurity on both sides of the adoption**. The child is insecure in not knowing how strong is this bond from adoptive parents – how committed are they to staying with it. And insecure children, despite their relative health, test out the adults of their family. Sometimes they do it aggressively, other times by adopting the behaviours of a younger care-eliciting child. When this goes on and on, and the child's temperament appears strange and unfamiliar, some adoptive parents are tested too much in the same way as a fostering placement is tested and is unable to go on. Crisis phenomena occur and the more committed families seek help instead of giving up or blaming the child.

Adoptive parents who are insecure about adoption are outwardly distinct from the secure ones.

The secure ones know quite a lot about children generally and are interested in what the particular child is like and how they will develop. If this development requires straight

answers or testing their origins, they make that possible without giving prejudicial information. They are able to let the adoptee differentiate into an adult with adult interests and finally develop a good adult/adult relationship with them. If they are anxious about reunion, it is that the adoptee won't suffer a major let down or be rejected. They are usually interested in the biological family and what they do without deprecation. It is rare to see a mother and an adoptive mother become good friends, and it can't come about any other way than with real trust, but I have seen it be ultimately good for the adoptee and his family.

The more insecure the adoptive family, however, the more they are worried that the child will leave them, judge them, and not want to know them, the more they will make up myths or stories to make the child think they are better off with them than they would have been otherwise, and the more there are stories that their mother couldn't keep them or didn't want them. The messages to the adopted child about biological parents may be blatant: such as: *"You'd have been starving in a humpy outside some little town."*, or subtle and projective*, "Your 'birth mother' seems rather brittle don't you think?"* Insecurity is not all or nothing: there are degrees of insecurity, and varieties - reflective of the adoptive family attitudes and preconceptions. Unfortunately there is no known way of screening out which adoptive families will be insecure, but there is the opportunity to educate them in the hazards and help them with common insecurities. It is to be remembered that most of the ones we are discussing are in the middle or top group of adoptive families, and not ones who are drunk, drugged, divided or displaced. They are essentially people who are trying their best and are deserving of our compassion for their own insecurity and distress.

The adoptee's insecurity is: *Am I a good enough kid and grateful enough for you to see me through my development without wanting to get rid of me?* - their attachment is essentially anxious.

The adoptive parent's insecurity is about*, "Did I really do well enough to have justified my having somebody else's child to rare? How do I keep the deep down guilt feelings quiet?"* An adoptive parent who has open communication with his or her spouse might be asking, *"Did* ***we*** *do well enough…?",* and even that sense of them doing it **together** is of immense value to the adopted child.
Some adoptive parents want school results and trophies on shelf, and, if they just happen without anxiety and pressure, that is fine. But the adopted child is left with a burden of feelings of how to come to terms with obligation and expectations of gratitude. The secure adoptive parent can talk openly about this aspect of adoption and express what they themselves are thankful and joyful about. The insecure adoptive parents want their due.

One aspect of *'wanting their due'*, is control and maintaining the relationship on their own terms through later life. Stierlin has studied the 'mission' that families give to children and that begins to be acted on in a deeper manner when they are in later adolescence. In many adoptive families it is to be outstanding in some manner, and generally to give the message of what a great family they were brought up in. If the pressure behind this is not too great and the means to this is flexible, it is restricting, but not too damaging. If the pressure is great and the means inflexible, then the child is often under unbearable stress.
To prevent age appropriate separation from the family at the age where their peers are becoming adults is another insecurity issue. The mechanisms seem to be universal in Western Culture. To do everything for them so they are dependent for living skills is a simple one, more serious is to undermine their sense of their own capacity to cope with adult life and relationships and live by their own decisions (this is a shame and self-doubt theme) and the third is about the triggering of guilt – guilt themes and guilt games are painful, the response often set up in very early life; and, at a deeper level, linked in the adoptee to his or her fear of abandonment that is easily displaced later onto their mother and how they will feel

when they meet her.

As I have pointed out in my earlier writings about the selection of adoptive parents, adoption motivation is very strong. I have already discussed such motivation factors as mutuality and a genuine interest in children as good outcome factors, and indicated that we are not discussing the family broken up by alcohol, or where a difficult marriage was to be temporarily propped up by the advent of a child. However it is important to remember that strong motivation themes, which may be very different between the couple and indeed their relatives, is a background to the development of an adopted child. The grandparent who rejects her adopted grandchild in favour of cousins for example, or the child with one parent who was not 'the adopter' in the first place, where the issue might be indifference: what difficulties does this make for a child's understanding of their place in the world? I mention these issues here, but they are available in more detail from my earlier writings.

In Erikson's terms, the stages of industry and identity in psychosocial development are a hard time for the adopted child, and, because they are the foundations for the later stages of intimacy and generativity that lead on to the child accepting themselves and their life, they are pivotal in the making of the person and the family of the future. While there are even echoes of adoption in society all parties to adoption require our compassion and support.

References

Erikson E.H. 1950. *Childhood and Society* Penguin Edition 1965 pp 239-236

Erikson E.H. 1968 *Identity, Youth and Crisis* Norton New York

Kraus J. 1978 Adjustment of Adopted Children and Demographic Profile of Adoptive Parents. Australian and New Zealand Journal of Psychiatry 1978 12(3), 181-187

Rickarby G. A. (1*976) Family Psychiatry and the Selection of Adoptive Parents* Australian Social Work, 31(2), pp 21-22

Rickarby GA. & Egan P.*(1980) Issues of Preventive Work with Adopted Adolescents.* Med. J. Aust 1: 470-47

Rickarby GA., Lee M.M., Said J. and Pauline Egan *(1981) Adoptive Families in Distress* Aust. Journal of Social Issues. Vol **16** Number 1 pp 32-36

Stierlin H. (1973) The Adolescent as Delegate of his Parents *Australian and New Zealand Journal of Psychiatry* **7** pp 249-256

POST-TRAUMATIC PHENOMENA FOLLOWING SEPARATION FROM A BABY by Geoffery A. Rickarby FRANZCP

Abstract
This paper deals with a range of post-traumatic phenomena that might be variously diagnosed under modern classifications of psychiatric disorder: commonly: Post-traumatic Stress Disorder 6, Panic Disorder, Dissociative Disorder and Major Depression, or, distressing phenomena, that, on the other hand, would not reach diagnostic threshold, yet still pervade and undermine the further life of those separated.
It describes the various traumas of mothers who lost a baby or young child to adoption or separation by fostering, and follows the sequelae of these traumas in the mother's future disorders, symptomatology and relationship difficulties. It draws on the author's previous work with adopted families and thirty years of experience as a Child Psychiatrist with a special interest in the survivors of adoption.
It considers post-traumatic phenomena as elements of dysfunction, that when identified, are likely to respond to appropriate treatment, in contrast with those elements of Pathological Grief which are only covered by newer layers of defense to reappear in different form.

Introduction

During the time of peak adoption activity during the sixties and early part of the seventies in Australia, some mothers were fearful for their own life because of awareness of the desperation to take their baby, and the callous indifference around them.(1) There was a proportion who were already highly traumatised because they had become pregnant under circumstances of sexual assault.

Others were subject to sudden procedures during their labour of which they had no foreknowledge, no explanation, and tried to understand their predicament through a drugged haze. A large number were teenagers who had to endure this experience without a supporting person present, spending much of their labour totally alone. Partners and relatives were kept away from the labour-ward. Those who were young adults with partners were unable to communicate with them. Drugging(1) with barbiturates, chloral hydrate or benzodiazepines was usual. Many had been incarcerated in 'homes', some with their street clothes confiscated.

A large group had no idea they were going to have their babies abruptly separated (3) from them within minutes after being born(1,) and moreover, in circumstances where they had pillows or other visual obstructions to seeing the baby placed on or before their eyes. In some centres they were tied to the bed.

Some had a parent who colluded with the obfuscation, and who were essentially part of the conspiracy that was mediated by the letters BFA on the file or the deceitful UB –ve (which stood for '*unmarried'… baby… remove*). The latter posed to the uninitiated as if it was a blood-group.

There are some factors that amplify and exacerbate the effects of fear and trauma. Being separated from close others is one. Personal isolation is another. This is more than the issue of being unprotected, it is to do with the lack of intimate feedback about the unique events occurring being normal and not frightening. Being subject to authority, particularly if that authority is not there as a caring agent is another. Being unable to understand what is going on, whether it is due to drugs, lack of information or helplessness is another. Dramatic and unfamiliar circumstances are others. Some people are especially sensitized to hospitals and medical procedures by their previous experience. In most mammalian species there is a

particular fear in a mother about having her baby taken from her by predators or dominant members of her own species.

Most women who have lost their baby have received some acknowledgment of various levels of grief. It was often only the insensitive, *"You'll get over it dear and be able to get on with your life again."*, right through to the acknowledgment that it may well be an ungrievable grief in the long term. With the trauma that occurred, there was little validation that the effects of this would also be long term. This is why this paper concentrates on helping unresolved trauma, because this is one area where damage may be helped to a degree that enables significant improvement in experience of life.

Processes of Trauma

In looking at trauma there is the "This happened" and the "Then they did this", aspect of it. But there is also the "I felt/I thought/nobody helped me/I was shocked/ I didn't believe it could happen/I was abandoned/ humiliated/or bullied and very afraid", side of it.

To cause **Dissociative Disorder**, the experience is so overwhelming emotionally, so extraordinary, and the loss so untenable, that the trauma memory is isolated, and it, and most of its associations are encapsulated away from the memory of the everyday self. It is important to realize that the memory in **Post Traumatic Stress Disorder** is also highly damaged. There the person suffers at the return of images from the height of their fear.

These might be as a still picture or like a short horrific videotape clip. Some people have a sound or a smell, such as the sound of the gas machine or a particular hospital smell. Most of the other memories leading up to it and after it are missing or distorted. The person with PTSD has these abnormal memories mostly dissociated, but they intrude in the thoughts as if of their own will, and are accompanied by the shock or terror of the moment. They also intrude in various frightening forms into their dreams. There is little control over these intrusions and the sufferer has to work hard in many ways to lessen both the intrusive images and their effects.(5)

These effects destroy everyday living. There is avoidance of anything that may remind the sufferer of the trauma, because even when they improve with time, there are trigger experiences that bring it back again. The sufferer is over alert, tense and highly strung. She is looking for the original experience to recur, or for something to bring on her PTSD symptoms.

Positron emission scanning shows large amounts of brain function taken up with this vigilant and avoidant mode. It is no wonder concentration, memory and attention are poor in those suffering from PTSD.

Whenever I saw or heard about mothers who attended Child Psychiatry clinics or was aware of great anxiety and avoidance through my consultation and supervision role, I would get somebody to ask about previous loss(2) or threat of loss. A wide variety of losses come out. Not only did one hear about babies taken in the years of adoption power and racial preoccupation, but of children who died from accident or illness, the effects of a still birth upon the whole family, the baby abused by a close relative or baby sitter where the truth is never known, and the child who nearly died, maybe hospitalized for years or forever changed by physical injury. These all have times of trauma, and crises of sudden shock.

From the other direction, when I hear stories of shock and trauma, I then look for the issues of fear and avoidance, and the **depression** that follows when the person is overloaded with PTSD issues and then decompensates. The severity of the depression is proportional to the emotional load of post-traumatic experience that is unbearable. Depression is also fed by

issues of grief, including all the 'what if' scenarios that intrude. The baby industry also put out a lot of cultural 'bytes' about the personal responsibility of the young mother for her own predicament. Guilt is one of the pillars of depression.

Sometimes in certain circumstances, the fear comes suddenly in such a way as to cause unexplained panic, fear of dying, losing control or going crazy, all this along with intrusive body changes - such as palpitations, tremor, sweating, choking, gut reactions and a secondary fear of the panic itself. This is **Panic Disorder6.**

Consequences of Trauma

The long term effects of trauma on the course of the mothers' lives and behaviours are most significant4.

What follows is a list of a few of the issues related to trauma as an example of its far reaching effects:

Ø In Australia nine out of twenty mothers who have lost a child to adoption have not gone on to have another baby. They give many reasons in which distrust is a major theme. Fear of hospitals, nurses, doctors and betrayal by their own families are common. Distrust of their own ability to stand against dominant and authoritarian others is another. Most will say they didn't want to think about it for years, let alone talk about it for fear of waking up all the feelings associated with trauma and grief. Many will say they are unable to develop that part of themselves that relates to babies and young children, and find themselves avoiding such circumstances in their greater families and friendship groups.

Ø Those who went on the have their next baby are able to tell of the detailed organization they brought about to have their baby in entirely different circumstances, and then highly supported by partner, friends and trusted relatives. They are frank in their awareness of their fear of losing their baby even under these circumstances. They are often shocked by the intrusion of the trauma and preoccupation with their first labour from many years before. The image of a child aged five or seven they do not know is with them in Labour Ward. Do they bond to their new baby easily; does their intimacy with their baby follow an easy and natural course? Even in the large group of such mothers I know who are not patients and not seeking help, I know it does not happen this way. The protection of themselves from traumatic memory and fears is itself enough to alter their relationship with their second baby. The difficulty of being close to their new baby while their grief is upon them7 leaves them little to enjoy. Beneath the surface is the thought that if they get close the loss will be even more unbearable.

Ø I see have seen many of these mothers in Child Psychiatry Clinics where they are so scrupulously caring for their child's safety and vigilant about any member of their own or spouse's family who looks as if they might take over the child, that the child picks up this anxiety and is confused and bewildered by its meaning, creating further difficulties in the mother/child relationship.

Ø Consider the mother whose baby has been taken after Children's Court proceedings when her baby has been injured and she has only suspicions and theories over which of her family members knows what happened - with her other children she is frightened for every bruise, protective of every 'Murphy's Law accident' that could possibly happen. When a baby or young child has been taken in racial circumstances, then every authoritative or confident person who turns up in the locality is a trigger for anxiety and distress.

If you look at trigger mechanisms that bring back post-traumatic phenomena, you get a broader look at effects of trauma. Trigger phenomena will rarely be rational and some of the links are lateral and the association not obvious. Some examples:

- Being examined by doctors.(particularly if the examination is gynaecological or obstetric)
- Hospitals and hospital gowns and smells.
- Nuns, D.O.C.S workers and Social Workers
- Somebody who resembles the matron of the unmarried mothers home' or the Social worker who orchestrated the adoption, or resembles a person with a significant powerful role in the loss of the child.
- Clinical equipment such as lights
- Noises made by metal vessels striking each other.
- Babies and children in certain circumstances.
- Finding out somebody they know is an adoptee or adoptive parent.
- Being exposed to other mothers' experiences of their loss.
- Somebody finding out they had a baby as a teenager. (The guilt and shame of the brainwashing is traumatic too)
- Being in a situation where they are under somebody else's control. (distrust) This may be simply being a passenger in a motor vehicle or aeroplane.

For some people it is just going out from home without a competent adult with them; and such people may have Panic Disorder with Agoraphobia.

Help and Treatment for Trauma Effects: Support, healing the wounded memory, and control of symptoms.

When seeking help it is always useful to distinguish frank trauma effects. Grief will always be meshed in with the trauma, and is indivisible from it, but dealing with the trauma can help with grieving some of the issues that are unable to be faced.

The therapy of trauma effects always depends on having somebody who can support you through the pain of traumatic events. In the instance of reintegrating dissociated elements of personality this is vital. Two together can face much more than one who is frightened. A lot of the training of a trauma counsellor is to know what is helpful debriefing and reintegration and gently encourage it – particularly not to interfere with the person's own way of doing it.

In PTSD, while this is important, it is also important that the person has an opportunity to heal their wounded memory. This can be helped by cognitive narrative of what led up to the traumatic image and how that situation led to the trauma experienced and then what happened following this. The setting of the room or event can be explored in detail and the aim is for the memory to be re-entered with **continuity** and **ordinariness** and for this memory to replace the traumatic intrusive one. One walks through the event in one's mind paying attention to the ordinary details as well as the extraordinary. When the patient is prepared, there is often the option of going back to the actual scene of the trauma and doing something ordinary, taking in all the details of the real setting as they are now.

Extensive cognitive behaviour review of the circumstance gives an adult hindsight view of the event, as well as its antecedents and consequences. In some circumstances there is a type of political anger that replaces the imprinted trauma, but this type of anger is nearly always preferable to the trauma because it can be subject to control and direction.
Then there are the therapies that bring about control of symptoms, so that you are able to go where you want to go and have the events and circumstances in you life that you want. These include cognitive behaviour therapies about the body's reaction to fear and stress, relaxation techniques practiced until they are second nature, yogas of various types, as well

as meditations using a variety of techniques. If these are practiced significantly and not given up soon after they are attempted, they are highly valuable. Stress prevention may be a significant part of this too. When the trauma is major, so must the work be major, to counter it. Always remember that those with PTSD are very vulnerable to substance abuse that may then create a huge barrier to their treatment and this must be faced first.
While cautious use of medication might be used with benefit during treatment, particularly where panic and/or depression are major features, most of the healing comes from the work that is done.

If the sufferer has trauma effects under control and is able to go places and do things she couldn't previously do, then she will be in better shape to tackle the mourning part of her grief, than when she was beset by the tension and avoidance of her post-traumatic symptoms and defenses

References:

1 New South Wales Parliament Legislative Council Standing Committee on Social Relations (2000) **Report 22 Adoption Practices 1950-1998 Final Report** pp 103-107

2. Bowlby J. (1980) **Attachment and Loss: Volume 3: Loss** Penguin Books pp122-123

3. Bowlby J. (1981) **Attachment and Loss: Volume 2: Separation** Penguin Books pp 228-229

4. Macleod A.D. (1994) *The reactivation of post-traumatic stress disorder in later life.* ANZ Journal of Psychiatry **28**:625-634

5 Walker E.A., Katon W., Russo J., Chiechanowski P., Newman E. and Wagner.A. (2003) *Health Care Costs Associated with Post-traumatic Stress Disorder Symptoms.* ARCH GEN PSYCHIATRY **60**: 369-374

6 The American Psychiatric Association (1994) **Diagnostic and Statistical Manual of Mental Disorders DSM IV** Washington D.C. 394 and 424-429

7. Raphael B. (1983) The Anatomy of Bereavement **Basic Books New York pp 252-254**