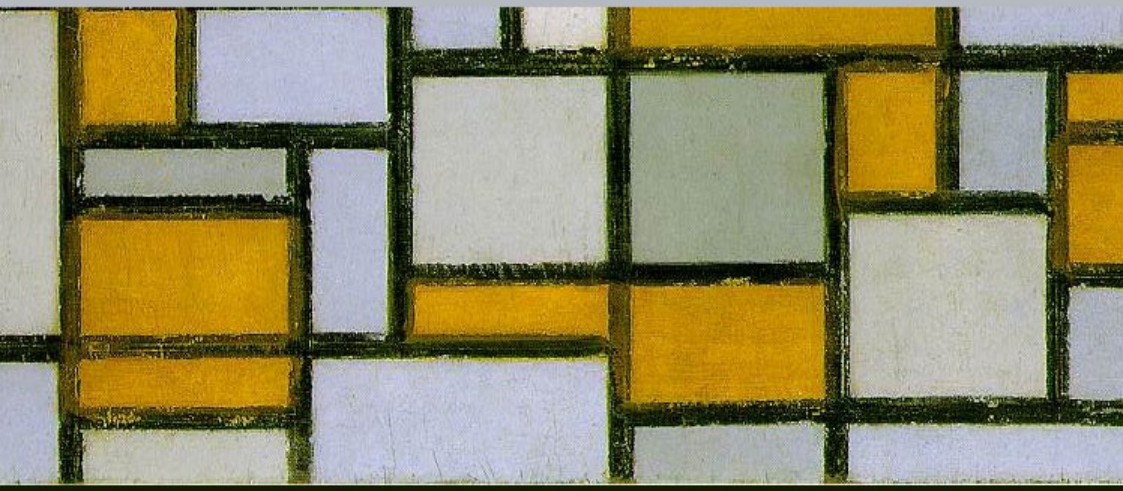
VIOLA W. BERNARD

ADOPTION



American Handbook of Psychiatry

Adoption

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Adoption

Through adoption society has established a type of family in which parenthood is based, not on having given birth, but rather on parental functioning and the ties of the child-parent relationship.[1] Adoptive family *formation* takes place for the most part during a circumscribed period of time: the children are still quite young and the parents are likely to be in their thirties or so. The adoptive family *process,* however, extends throughout successive stages of the life cycle for each of the participants, during which time they influence each other's existence fundamentally. It is from this dynamic of adoption that its powerful potential stems for preventive psychiatry—particularly for the children, whose still unfolding development is so critically at stake.

Specialists in the fields of child health, child development, and child welfare are in general agreement that, for dependent young children who are without parents, a permanent family of their own that has been socially created can offer optimal protection against the damaging effects of parental deprivation. To be sure, children born into the families that raise them are not thereby automatically insured against developmental hazard; but children who lack parents and family are clearly at great maturational disadvantage. They constitute the primary population at risk with which this chapter is concerned.

The number of such children in any one year far exceeds the number of those adopted. Thus in 1970, the last year for which national child welfare statistics were reported, about 89,200 children were adopted by nonrelatives, and another 85,800 by stepparents or other relatives. Many thousands more, however, were at that time living out their childhood in long-term foster care or in child-care institutions; still others, their numbers unknown, were being repeatedly shifted about, through informal arrangements, from one to another of a succession of temporary caretakers.

It is central to my orientation vis-a-vis adoption that any valid assessment of its psychosocial value must be measured against the yardstick of this massive unmet need; that adoption is, 011 the evidence, the plan of choice to prevent or mitigate the destructive effects of such need; and that adoption is essentially an *affirmative* experience.

In this chapter I shall focus on a particular population—that of adoptive families—from the standpoint of primary, secondary, and tertiary prevention. That is to say, I shall explore how certain concepts, knowledge, and techniques of psychiatry may be applied, in concert with elements from other fields, at successive stages of adoptive family formation and process, so as to help strengthen the psychological health of this population group.

From the perspective, then, of mental health prevention at its three

levels, a reciprocal relationship exists between adoption[2] and psychiatry. Adoption can contribute to the psychological health of its key participants, and psychiatry can contribute to the psychological success of adoption. Or, to put it another way, each of these can help prevent or reduce obstacles to the emotional well-being of a sizable and specific population of children and adults.

Although, as stressed above, adoption can have significant influence on mental health, many different sets of factors determine whether in any particular instance that influence is positive or negative. It has high potential for a positive impact in that adoption can be a means for: supporting sound infant-child development by preventing parentlessness; making the fulfillment of family life possible for couples who are unable to bear children, and whose longing and potential for parenthood would otherwise be thwarted; enhancing the growth-promoting potential of the family as a whole when parents adopt who already have children; finally, as a conflict solution, relieving pathogenic stress for many of those who, having given birth, are unable, for one or another reason, to function as parents.

Adoption services are mainly the responsibility of social workers in both voluntary and public welfare agencies, but they involve other professionals as well in various capacities: psychologists, pediatricians, psychiatrists, nurses, geneticists, lawyers, and others. (There is marked

variation among agencies in this regard.) The rationale underlying adoptive practices is synthesized by drawing upon the theories, assumptions, and data of other fields, such as child development, psychoanalysis, and social science research. Prevailing sociocultural conditions at any given period, as well as factors of expediency, also influence adoptive service patterns and adoption policy.

In 1955 the Child Welfare League of America[3] convened a National Conference on Adoption, attended by members of allied professions, including this author, to examine and exchange ideas and information about the complexities of adoption. Since then major changes have evolved, the more so in the past few years, so that adoption today is very different in many fundamental respects.

These changes have critical relevance to the mental health implications of adoption and to the ways in which the content of dynamic psychiatry and the work of psychiatrists can help maximize the psychic well-being of adoptive families.

Steps and Stages in Adoption

For readers who are unfamiliar with the sequence of steps and stages in adoption, it may be useful to review these very briefly, since it is according to that sequence that considerations of preventive psychiatry will be explored here.

But first it should be explained that in this overview, and, indeed, throughout the chapter, only those placements that are arranged by authorized agencies, public and voluntary, are under discussion. It is true that many independent adoptions turn out well and that many agency adoptions turn out badly. On balance, however, agency placement offers by far the greater advantage and protection to the greatest number of those concerned, both children and adults. My stand on this question, discussed more fully elsewhere, is in keeping with position statements by several medical and social welfare organizations. Efforts to educate the public, plus stronger laws against the black market in babies, seem to have had some effect. In 1970, slightly more than three-quarters of the reported placements in the United States (for nonrelative adoption) were through agencies. This figure represents a steady rise since 1957, when the numbers of independent and agency placements were almost equal.

Preplacement Phase

Couples who want to adopt and *agency workers in search of adoptive homes* for children in their care undertake a series of meetings and interviews. Through these the couples learn more about the realities of adoption; they explore and confront their own motives, conflicts, fears, and preferences; and they reassess their decision to adopt. If they do go on they have thereby become better prepared for the actuality of accepting a child as their own. The agencies utilize these interviews for the dual functions of assessment and of helping with problems about adoption through anticipatory guidance. The sessions are a way of screening out and screening in couples, on the basis of their potential as adoptive parents in general, for certain kinds of needy children in particular, and finally, if agencies and couple decide to go ahead, for a specific child.

Biological parents, of whom a majority are unwed mothers (88 per cent of the children adopted by nonrelatives in 1970 were born out of wedlock), can be helped through counseling with their conflictual decision making about adoption and with the process of surrendering their baby to the agency, which then becomes the guardian pro tem—that is, until legal adoption has been consummated.

Society's responsibility for children whose parents have been found to neglect them is carried out by authorized child welfare agencies, through providing foster homes or institutional care for these children. It is important

that such agencies, which are charged with strengthening family relationships for the children in their custody, reach out actively to help these parents—often themselves the victims of parental deprivation. In combination, psychiatric consultation, ease work, and practical aid with social, economic, and medical problems may mobilize latent parental strengths and thereby prevent family breakup; they may, on the other hand, lead to the diagnostic conclusion, with or without parental concurrence, that family reunion is not feasible and that a permanent adoptive home for the child is the plan of choice.

Parents who have come to agree with this conclusion, through such a process of help and clarification, free their child for adoption through voluntary surrender of their parental rights. According to present laws, however, most of the children whose parents neither free them for adoption nor undertake their care are consigned year after year to the limbo of indefinite temporary care.

Yet there are situations in which courts may intervene despite the failure or refusal of parents to surrender a child. Thus, where parents are found to have abandoned the children or to have left them for long periods in foster care without any meaningful contacts or efforts to plan for the future, the courts are empowered to terminate parental rights and to give guardianship to the agency that has custody of a child, with authorization to

place for adoption. Before such a determination is made, it is important that the aforementioned therapeutic effort and differential diagnosis on the part of the agency should have distinguished a case in which legal retention of family ties is in the best interests of the child from one in which it is not. The agency will thereby have become equipped to present evidence on which the court can base a considered and sound decision.

For the children the agency's preplacement services differ in many respects, of course, as between infants and older children. In general, children are cared for in agency nurseries or temporary foster homes, where their special attributes are studied and their special needs met, and where their development is assessed. Infants are placed in adoptive homes as soon as one is available, depending on factors referable to the baby's condition and history, as well as the legal status of his surrender. In some instances it is feasible to transfer newborn infants directly from the hospital; older children, however, need various forms of specialized help in overcoming the effects of prior traumata, in psychological preparation for adoption, and in understanding and participating in the placement process as much as possible. Helping them to comprehend and to have a say about what is happening in their lives prevents or reduces painful and detrimental confusion and the sense of being a helpless pawn.

Between Placement and Legal Adoption

For the new parents and the children, whatever their age, the child's actual entry into the home as a family member is a critical, emotionally laden event in the adoptive sequence. Sensitivity in the way it is brought about, together with understanding support in the initial postplacement period, is especially important for all concerned. During the months before legal adoption can be consummated— state laws differ on the time requirement— agencies must maintain supervisory contact, based on their continuing legal responsibility for the child's welfare. The agency workers try to implement this contact by offering practical and psychological help. The parents' reactions to the evaluative function, however, tends to limit how fully they can, at that same time, accept and make use of the help. Group meetings of couples who are all going through this experience, for the discussion of their common problems, seem particularly useful, perhaps because they are less threatening than individual parent-worker contacts. This psychodynamically active period of family formation involves many different and complex ways in which the adoptive child and his new parents —and new siblings, too, in some cases—start to work through and establish their relationships.

For the biological parents, usually the mother, there is a period of time—it varies in duration, depending on local laws—after signing the surrender during which she can change her mind before the adoption is made legally final. This is a means of protecting her from hurried decisions made under the

pressure of strain and anxiety. Appropriate practical and counseling help before and during her decision to surrender, and the availability of such help in the immediate weeks thereafter, can be of the utmost value in the protection of and planning for her own and her child's best interests.

Poignant court custody battles have dramatized the pressing need for adoption law reforms. (Anna Freud's seminars at Yale Law School have exemplified some of the potentialities for primary prevention between the broad fields of law and child development.)

Postadoptive Phase

Since the postadoptive period extends for an indefinite time after legal adoption, one may think of it in both short- and long-range terms. A number of agencies offer adoptive parents individual counseling and group meetings at such key times as just before their children are ready for school. Agency provision of individual consultation and group counseling for adoptees at the time of adolescence is another instance of timely intervention. Aside from adoptive agency service, adopted children and parents utilize the full range of public and private social, health, and mental health services that are available generally.

Trends in Adoption Practice

Outstanding among the changes occurring in adoption has been the widened range of children who are considered adoptable. For a long time such children were almost exclusively white infants, with no detectable defects or deviations, physical or psychological. Increasingly in recent years placements are being made, and homes recruited, not only for these infants but also for older children, children from minority groups and of mixed racial and religious background, and children with various physical, emotional, and intellectual handicaps. These changes in adoptability have been paralleled by changes in eligibility criteria, for adoptive parents, who are no longer drawn predominantly from among infertile couples. The psychic correlates of both these sets of changes profoundly affect every phase of adoptive family dynamics, and hence the role that preventive psychiatry can play in relation to them.

It has been customary to refer collectively to these more recent child entrants to adoption as “the hard to place” (agencies now refer to them as “children with special problems”). While descriptively this is true, such lumping together of children who differ so basically from one another tends to obscure their far more salient particularities. It is these that dictate the specifics for applying mental health concepts and methods on their behalf to adoptive service policies and practices.

Closely linked to the foregoing has come the recognition that it is the *well-being, of the children* that is the primary purpose of adoption services. As an adaptive solution adoption has been a creative way of balancing the needs of adoptable children, of adoptive couples, and of parents who could not function as such. That balance has now shifted decisively in favor of the child. Every child who is capable of family living is seen as entitled to a permanent home of his own.

Commitment to this philosophy has led to an enormous increase in the numbers of children for whom adoptive homes are now being sought. Since this has been coupled with the hugely escalating number of children born out of wedlock each year—about a third of them find their way into adoption—the need for homes has greatly outdistanced their availability, even though the number of applicants has also been increasing greatly throughout the past decade.

The relative decline in the applicant-child ratio does not hold true, however, for healthy white infants (nor recently for black infants either); on the contrary, the number of these that are available for adoption has been markedly decreasing. (Unfortunately this seems to be reviving a black market in such babies.) Apparently this is due to at least two factors: (1) liberalized abortion laws and wider use of contraceptives are reducing the number of unwanted babies who would otherwise be given up for adoption; and (2)

many more white unwed mothers are now deciding (as have their nonwhite counterparts right along, largely as the result of there being fewer adoptive opportunities available to them) to keep and rear their infants. One can surmise that more tolerant community attitudes toward illegitimacy, with lessening of stigma, is at least one determinant of this.

It does not seem appropriate to the purposes of this chapter, nor is it feasible, to try to describe the current picture of adoption with any degree of completeness.[4] In many respects the situation is in flux at the time of this writing. The available statistics are not up-to-date enough to reflect adequately the rapidly moving situation. Indeed, it should be pointed out that much of the literature on which this chapter must of necessity draw is already, in a number of respects, out of keeping with many current actualities. Two trends, however, in addition to those that have already been referred to, do seem to warrant special mention from the standpoint of primary prevention.

For one thing there has been considerable gain in the social acceptance accorded adoption; this, of course, has been of value in terms of heightening the self-esteem of adoptive family members and lessening their need for concealment, with all its attendant emotional problems. In fact, many adoptive parents have formed highly vocal and visible organizations. The sharing of interests at both the personal and societal levels as well as the

concerted approach to common problems, helps these parents to dispel feelings of isolation. Chapters of the National Council of Adoptive Parent Organizations are working actively for legislative reforms and for the improvement of public attitudes toward adoption. Also the Open Door Society, whose members are adoptive parents of minority group children, seeks to encourage that particular type of adoption.

Placements in Infancy

As of 1970, more children were being placed at earlier ages (two-thirds of all the children adopted in 1970 by unrelated persons were less than three months old when placed in an adoptive home). This reflects the influence on adoptive practice of recommendations made by child development and mental health specialists that, in the adoption of infants, the most favorable time for placement, from the standpoint of primary prevention, is during the first few months of life. It is generally thought that such early placement can prevent or mitigate certain adverse effects on the child's development of prior maternal deprivation and of maternal separation. Moreover, such placement permits the early establishment of health-conducive patterns of mothering and parent-child relationships.

Yarrow's investigations are of particular value in this regard. Within the overall concept of maternal deprivation, he has distinguished four major

types of deviation in early maternal care. Maternal separation is one of these; and, with regard to it, six different kinds are identified, with correspondingly different effects on the child's subsequent development. The most lasting and damaging effects on mental health were found to occur when permanent separation from the parents was followed by repeated separations from subsequent foster home placements.

Except for newborns who go directly into their adoptive homes, children are undergoing, at the time when they are being placed in their permanent adoptive homes, at least one separation—from whoever it was who had been taking care of them. But, as Yarrow's distinctions emphasize, separation experiences are not identical by any means. He and Goodwin studied the effects on children who have been adopted as infants of the single separation from the agency's foster home, following which the new permanent mother figure had been immediately available. They reported finding few long-term personality disturbances, when the children were five years old, that could be attributed primarily to the early separation experience.

They did note, however, that there might be a critical period of immediate reactions to the separation. As early as three months infants were responding with disturbances; by six months there were fairly severe reactions. All those children placed after six months of age, however, showed

some disturbance—for the most part quite marked. The infant's vulnerability to discontinuity of the mother figure may be related to his capacity at six months for focused attachment to her as a particular individual. Yarrow suggests that if the separation takes place when the "stranger reaction" is at its height, a change of the mother may be extremely disruptive to the infant who, at that time, is developmentally in an active phase of establishing an object relationship with the mother figure. Yarrow and his co-workers, however, found no significant differences, when the children became ten years old, on a rating of overall adjustments between those who had left their foster mothers before and after six months of age.

According to their research, infants who are moved into adoptive homes from a prior temporary foster home tend to experience separation without the complications of maternal deprivation. For them the long-term effects of separation stress reactions, at placement, on cognitive and personality development are much less important than the quality of mother-infant interactions during the first year and the subsequent range of relationships and life experiences that serve to mitigate or reinforce the impact of the original separation stresses.

Because of the transactional nature of parent-infant relationships, early placement also favors arousal of emotional involvement in the baby on the part of the new mothers—and fathers—and thus stimulates parental

capacities. This is all the more true of couples who are adopting their first child, particularly if they are infertile and have not gone through the parental role preparation of pregnancy.

As with all parenthood there is great variation, along multiple dimensions, among “good” patterns and styles of adoptive parenting. Aside from obvious external differences among infants who have been placed for adoption, they also differ from one another, of course, with regard to such individual attributes as temperament, innate constitution, predispositions, and latent vulnerabilities and talents. As yet we know far too little about which personality characteristics of the parents can be matched with which infant characteristics in order to enhance the chances for optimal adoptive family psychological outcomes. Agencies have by now discarded their former practices of attempting to “match” adoptive parents and children in terms of physical appearance. It was found to be needless for mutual identification; indeed, it can be detrimental, by playing into a need to deny the fact of adoption, based on unresolved feelings of discomfort with it. But research that can deal with the complexity of relevant variables in such a way as to arrive at a greater understanding of subtle types of parent-infant matching could have great importance for primary prevention.[5]

Patterns and Styles of Adoptive Parenting

The contrasting effects of two good but different kinds of mothering on the same adoptive child is well illustrated in Krugman's "A New Home for Liz: Behavioral Changes in the Deviant Child." The facts of this case may be paraphrased and condensed as follows:

> This child, who had been under the agency's care since birth, was placed at three months in an adoptive home where the same agency had placed another baby some years before, who had adjusted well, thus attesting to the couple's adoptive parental competence. Liz, however, showed markedly deviant development in her new home. Her mounting behavioral symptoms, panics, and distress became so intense that when she was 34 months of age, the agency's psychiatrist, psychologist, and social work staff decided on the drastic therapeutic step of a total change in home milieu. The child was therefore removed from the adoptive home and transferred to one of the agency's supervised boarding homes. There her behavior and adjustment improved so drastically that at five years of age she was replaced for adoption. In this second adoptive home she adjusted well, without any unusual efforts or special plans being made on her behalf. Her maturational progress continued till age six, when the case report stops.

Krugman attributes the child's remarkable improvement in behavior and symptomatology in the main to the very different styles of response to Liz and her problems manifested by the adoptive and the special foster home mothers.

This case illustrates the fact that under certain circumstances it can be therapeutic to uproot a three year old from her familiar and apparently benign social and physical environment by moving her out of it into a totally

strange new life situation. But how can we reconcile this with the findings, cited above, about the damaging deprivation and discontinuity of multiple placements? Would not such separations be all the more traumatic for an unstable child like Liz? As a pivotal criterion for distinguishing between traumatic and therapeutic separations, one needs to ascertain *from* what and *from* whom the child is separating, and *to* what and *to* whom he is going. Permanence is the unique attribute of adoption as a form of substitute family care; it is what gives it such power to prevent the ravaging effects of parental deprivation. Yet if the wrong child happens to be with the wrong parents, this very permanence can render such an adoption pathogenic by locking parents and child into lifelong destructive relationships.

In this instance, therefore, it was the agency's responsibility to evaluate and act before the finality of legal adoption took place. The appropriate emphasis for describing the move Liz made from her first adoptive home would seem to be that of *gaining* an environment in which her development could go forward, rather than that of *losing* a mother and a home that were actually imperiling her future sanity.

A more clear-cut case of secondary prevention, achieved by removing a nondeviant child from an unsuitable adoptive home prior to legal adoption, may be illustrated by the following case vignette from my own experience.

Sarah was already almost 11 years old when her pressing need for adoption became evident. At that time she was indeed “hard to place,” even more so then—it was in the mid-1950’s—than nowadays. When she was nine her mother, who was unmarried, had to enter the hospital, where she died four months later. Because of a series of deaths and rejections by relatives with whom she might have lived, Sarah spent one and a half years in a small children’s institution. This deeply hurt child, who had unusual strengths of personality and intellect, was placed for adoption, following some case work help in the institution and psychiatric consultation at the adoption agency to evaluate her adoptability. The preadoptive study of the couple with whom she was placed when 11, as well as the placement process, were speeded up because even the institution was about to be closed down.

After the newly formed adoptive family had spent one summer together, a basic incompatibility became evident. The parents, especially the mother, sought my assurance as the psychiatrist for the agency that, in effect, everything about the adopted child could be changed to their specifications as the condition for keeping her (these specifications struck me as befitting a trained seal more than a daughter). Sarah, who had already been acutely sensitized to separation and bereavement, was terrified of losing this last semblance of a home. Consciously she desperately tried to please and to mold herself into what was wanted; unconsciously she reacted against such basic rejection with symptomatically disguised forms of protest, which the parents

and the guilt-ridden child herself interpreted as further proof of her unacceptability.

My initial clinical objective was to help preserve this adoption by working with both the parents and the child. Protection of Sarah against still another abandonment seemed of overriding importance. Nevertheless, I was forced to the reluctant conclusion that for Sarah to remain in such an intractably pathogenic situation would be untenable. It was a momentous decision! This youngster was already showing psychic ill effects from all the discontinuities and misfortunes she had previously experienced; to remove her from this adoptive home was bound to entail trauma in the here and now, which could harm her further—perhaps seriously. Not to remove her, however, would destroy her chances, I felt sure, ever to reverse her emotional difficulties or to remotely fulfill her substantial potentialities. Upon concluding that these long-range dangers outweighed the short-term risks, I recommended, and the agency agreed to, her therapeutic removal. The adoptive parents not only agreed but were distinctly relieved.

To inform Sarah and explain this to her was one of the most painful tasks I have encountered. It was a psychiatric equivalent of radical surgery. Every ounce of her energy for survival was mobilized in fighting to stay in the placement. It took all the confidence that I could muster in my professional judgment to almost literally tear this child away from the loveless home to

which she was clinging with all her might; it felt to her like the only alternative to an engulfing world of nothingness.

This is a vignette, not a full case report; its intent is to illustrate a limited aspect of secondary prevention in adoption. Suffice it to say, therefore, that four months later, after a period of special foster care, Sarah was once again placed for adoption. Legal adoption followed at age 13. During the interval between adoptive placements the case worker and I both worked intensively with the child, while the agency made a strenuous and at that time innovative home-finding effort on her behalf. By enlisting the cooperation of all the agencies in this and neighboring states, the number of adoptive applicants who could learn about and become interested in Sarah was greatly multiplied. [6] This made it possible to select from among quite a few families—a process in which Sarah took an active part.

Did that decision in 1955—to separate Sarah from her first adoptive home—turn out to have been so vital to her subsequent mental health? Because of the unusual opportunity I have had to follow the course of her development up to the present time, I can answer this with an unequivocal "Yes!"

Sarah and the members of her new permanent family had a turbulent period of initial adjustment; but they weathered it, thanks to the positive

emotional qualities and effort each brought to their interrelationships. In her late teens, while at college, Sarah resumed contact with me (directly this time, not through the agency). She felt she needed psychotherapy, as, indeed, she did. She had matured and grown secure enough to want to work on her unfinished emotional business. In debating whether I should become her therapist, as she requested, I weighed the possible drawbacks of having intervened so actively in the realistic circumstances of her childhood against the advantages of my continuity between epochs in her life. I decided in favor of the latter, and it did prove to be a major therapeutic asset. Sarah achieved an excellent treatment result. I still see her from time to time, as when she came by to show me photographs of her husband and their little girl.

When the adoption agency first intervened—Sarah was just under 11—her prognosis for healthy development was poor, in the absence of special remedial measures. Removal from the first ill-chosen adoptive home was a crucial crossroads experience, prerequisite to the effectiveness of everything else that helped to undo the psychic injuries she was already then showing. It made her accessible to the emotional nourishment of the adoptive family process, which in synergistic combination with psychotherapy seemed to have made a superior adaptation possible for this particular young woman. I have learned a great deal from her, over a span of 18 years, about how to help others in comparable predicaments.

The cases of Liz and Sarah were cited to illustrate several points. Although in both these instances the first placement came to grief and was terminated, it would be incorrect for the reader to conclude that agencies frequently remove children once they have placed them for adoption. On the contrary, this seldom occurs.

Criteria and Procedures for Parent Selection

Agencies have been very reluctant to disrupt placements already made. Instead, their efforts have been focused on preadoptive procedures of selecting and preparing particular parents and children for making a good life together. In recent decades as the weighting of factors has shifted with regard to what is considered desirable in adoptive parents— from affluence and religious and civic standing, for example, to psychological capabilities for parental competence and relationship—the concepts and methodologies of psychiatry and psychoanalysis have come to play a greater role in determining appropriate criteria and ways of evaluating adoptive applicants.

As psychiatric consultants to agencies, several of us have sought to contribute to this aspect of adoptive practice because of its obvious strategic importance to primary prevention. It would certainly do violence to the true complexity of variables at issue to develop a check list, as it were, of qualifying and disqualifying psychological items for adoptive parenthood, or to seek a single personality stereotype or hypothetical paragon as a model among adoptive applicants. The basic personal qualities that have been sought as mental health assets for all adoptions, whatever the age and characteristics of the child— qualities that may be expressed through a diversity of life styles and personality patterns —concern the capacity for warm, mature love for a child as an individual in his own right, by each parent

and by both as a unit[7] along with a stable compatible marriage and the flexibility to cope with life's unpredictable vicissitudes.

Criteria that are more specific to adoptive parenthood also enter into preadoptive assessments. Which infertile couples, for example, can or cannot feel comfortable enough about adoption as a substitute form of family formation really to accept such a child as their own? Have various emotional problems around their infertility been sufficiently resolved so as not to impair how they perceive and respond to the adoptive child? Or in regard to transracial adoptions, for instance, does a particular white couple want to adopt a nonwhite youngster as a way of making a sociopolitical statement, or is it primarily for love of the child? Can another couple, who would like to adopt an older child, allow him his memories and the sense of his past without feeling it as a threat to their sense of parenthood? And are still another couple, eager to adopt a handicapped child, too caught up in their own rescue fantasies to be able to know the child as the person he really is?

Evaluation of applicants' motivations to adopt—conscious and unconscious—requires a high degree of skill, sensitivity, and objectivity. One must know how to listen for meanings behind what is said, and to understand how these are likely to affect the adoptive family process. The screening out of those with manifestly neurotic motivations is a valuable means of preventing childhood maladjustment. Certain motivations are also generally

deemed to be contraindications for adoption, at least at the time when the application is being made. The desire for an immediate “replacement child,” for example, to relieve the bereavement of a couple whose own child recently died is almost bound to lead to misery: disappointment for the parents and rejection for the child. Instead, such couples should be invited to reapply, if they still want to adopt, after having gone through a mourning process for the child they lost. Nor should adoption ever be considered, of course, as a means of trying to hold together a faltering marriage.

However, unless relatively clear-cut reasons are uncovered why adoption would turn out to be unsound, psychodynamic insight in current adoptive practice is being utilized more for assisting applicant couples to become parents than for ruling them either in or out, by way of some diagnostic prediction, in advance of their actual experience with an adoptive child.

The rationale for this shift in emphasis between the intertwined processes of preadoptive appraisal and enablement in favor of the latter rests on certain factors. One of these has to do with greater awareness of the limits to accurate prediction of emotional capabilities for adoptive parenthood, in both the near and the far future, before the couple has even begun the process of becoming parents.

We know that feelings of parenthood develop as a process over time, and that this holds true for both biological and adoptive parenthood. The experience of pregnancy serves as a psychobiological preparation for motherhood that adopting mothers—at least those who are childless—lack. The interval between agency approval of a couple's application and placement of the child provides a compensatory opportunity in such instances to prepare emotionally for the mother role—a process that a psychologically sensitive case worker can facilitate. But for most couples the period between their application to adopt and its approval by the agency is a time of stress and uncertainty. Far from using this interval as an occasion to face and work out conflicts and anxieties that the much desired adoption may unconsciously evoke, they more often tend to defend themselves against the risk of agency turndown by not letting themselves believe that they will really become parents. Therefore, protracted agency preadoptive studies, intended to make sure of selecting "good couples," have in many instances defeated their purpose.

On a continuum of suitability for adoptive parenthood, most applicants are in the middle range. Selection among these entails such subtle differentiations that, in their case, agency overreliance on predictions about adoptive outcome, prior to placement, is not warranted. (A more feasible aim at that stage, in terms of reliability, is to identify and screen out, from the psychological standpoint, the more definitely unsuitable applicants, such as

Sarah's first adoptive parents.) The conditions of agency practice add to the reasons for this. Such a diagnostic attempt demands unrealistic levels of skill on the part of most social workers; moreover, it has to be carried out within the relatively few interviews that comprise an adoptive home study. Furthermore, applicant couples understandably try to put their best foot forward and tend to conceal or misrepresent what they think might disqualify them. Another frequent source of error is the worker's own unconscious attitudes and prejudices; despite her best efforts these may influence her diagnostic judgments.

Lest this signify to the reader that preadoptive parental appraisal is useless, it should be noted that according to one study, even those families with intervening "unpredictable" disruptions that seemed to be associated with the children's maladjustment have shown in retrospect certain signals of disturbance at the time of adoptive study. With keener diagnostic alertness to these clues in the first place, the problematic nature of these homes might have been predicted after all. If so, adoptive maladjustment might have been prevented either by the agency's not placing the child in the home or by appropriate interventions as indicated—not only before legal adoption, but also after it.

The possibility for such interventions goes to the heart of profound changes in emphasis with regard to adoptive services today: greater

emphasis on facilitating the parental potential of applicants and on helping them with problems than on hyperselectivity; greater emphasis on services to parents and children throughout the adoptive experience, not only in the stages before legal adoption, but extending on after it. These changes follow from agency efforts to cope with new situations : in sharp contrast with the past, there is now a shortage of applicants relative to the increased numbers and kinds of children for whom adoption has become a recognized right. In response to the pressing need for homes, especially for nonwhite and older children, and in the light of improved research, many earlier requirements for adoptive parent eligibility have been revised, relaxed, or dropped. An intensified search for more homes, in relation to need, is also being carried on by a diversity of other changes in practice. Among these are the use of TV and public education programs for recruiting homes for children with special needs.

The magnitude of the problem with regard to nonwhite children may be conveyed by 1970 figures from 240 agencies, which show that 116 white homes were approved for every 100 white children available for adoption, while only 39 nonwhite homes were approved for every 100 nonwhite children reported as needing adoptive placement. According to the latest published estimate (1970), the percentage of all children adopted who are black or who belong to other minority groups has not risen significantly, despite special efforts by social agencies to find adoptive homes for them. In

1969 children from these groups constituted an estimated 10 per cent of nonrelative adoptions. Published figures for 1970 reveal a 2 per cent increase. In that year 12 per cent of all nonrelative adoptions were of nonwhite children.

One of the most promising among the new ways of reducing this shortage of homes is a subsidy, through legislative provision, to parents who could not otherwise afford to adopt. Not only does this enable a larger number of less affluent black couples to qualify for adoption, but also it makes it possible for black foster parents to convert their status to that of adoptive parents when their relationship with the child and his legal situation warrant this.

The Children's Aid Society of Pennsylvania has reported on a study of black adoption families who participated in a so-called quasiadoption program. Although these couples were interested in undertaking long-term care of foster children, they were ambivalent about assuming the financial and psychological responsibilities of adoption. They were subsidized as foster parents and also given active psychological and social help by the agency, with the understanding that this might lead to their deciding to adopt. Concurrently the agency worked with the children as well. The study compared 50 black families who adopted through the traditional methods of that agency and 50 who adopted through the subsidy program—a program

that had doubled the number of homes available for the permanent placement of black children.

Transracial Adoption

Transracial adoptions, which are increasing, constitute another alternative for minority group children who would otherwise grow up without any family. American Indian, black, and Oriental children, as well as those of mixed racial backgrounds, including part Mexican-American children, have been placed in Anglo-American Caucasian homes at an accelerating rate in recent years. In discussing the psychodynamics of transracial adoptions, Marmor has suggested that the psychological qualifications of such parents should include, in addition to the basic criteria, their relative freedom from ethnocentricity and their minimal dependence on family and community approval.

Between 1958 and 1967, 355 homeless American Indian children were placed for adoption with white families by agencies affiliated with the Child Welfare League of America, in a demonstration project that the League undertook in cooperation with the Bureau of Indian Affairs. Fanshel has just completed a study of 96 such families, living in 15 states, to develop knowledge about the characteristics of those who adopted these children. He also sought to learn about the phenomenon of adoption across ethnic and

racial lines, as well as to develop a five-year follow-up picture of the experiences encountered by these families and children. The children came from tribes in 11 states. He found that the adoptive parents, rather than being a homogeneous group, represented a cross-section of attitudes among Americans. Although their political and philosophical views do not appear to have been an important stimulus for the adoption, the parents of these Indian adoptees did evidence more independence of mind and a stronger civil libertarian view than seems to have been true for adoptive parents of white children—a finding that supports Marmor's suggested qualifications for transracial adopters.

On the whole the children seemed to be doing remarkably well from the standpoints of physical health, cognitive competence, personality development, behavior patterns, and "imbeddedness" in their adoptive families. With regard to the parents most of them appeared to be very positive about the adoption. Many of them recognized that there might be rough periods ahead for their youngsters around problems of dating and of their sense of personal identity and worth, especially when they reached their teens. They were planning ways of protecting the children against the ill effects of racial difference, in part by trying to foster in them a strong sense of the value of their own backgrounds.

As Fanshel points out, there have been important changes in the

American Indian struggle against social injustice during the decade or so since this project began—changes that have made for conflicting attitudes among Indian groups about transracial adoption.

It might be added here that comparable conflicts are also manifest within black communities about the transracial adoption of black children by white parents. On the one hand, given the still current social circumstances that have deprived so many nonwhite children of families of their own race—biological or adoptive—the data show that transracial adoption does provide these children with a growing-up experience of far greater emotional security than the damaging life situations they would otherwise face. On the other hand, a segment of the black movement has renounced the goal of integration, at least for now, as a threat to their people's effort to achieve a positive sense of individual ethnic identity and group unity, which they regard as essential to their fight for equality. On this basis they sharply oppose the adoption of black children by white parents.

Close family attachments between parents who are white and their black or partly black children are epitomes of racial integration. It is ironic, therefore, that these transracial adoptions have come under fire from opposite directions—from white racism and from black militancy. Agencies, however, favor this kind of family formation as a here-and-now solution, at least so long as the relative scarcity of black adoptive homes persists. Most

recently, thus not yet in published reports, it has become generally possible for agencies to find black homes for adoptable black infants; it is the older nonwhite for whom the shortage of homes is most acute.

Some guidelines for recruiting and selecting families that can enjoy transracial adoption and experience it constructively have been emerging from the experience to date. Agencies, for instance, recognize that some couples are able to accept American Indian or other nonwhite children, including at times children of mixed black and white backgrounds, but are unable to accept fully black children. Such applicants are encouraged to acknowledge and explore these attitudes, which are taken into account in determining the kind of child to be placed with them. Agencies are also tending to place black or interracial children with fertile couples who have already borne children, but who are interested in what is now referred to as "room for one more." Many of the case reports of these placements reveal how greatly those children who are already part of the family can help the newly arrived child—often in ways in which the parents cannot—with his initial adjustment and with the process of becoming a full-fledged family member. (This is generally true in the adoptive placement of older children, transracial or not.)

In addition to the professional literature on this subject—Fanshel's book, incidentally, contains a very useful list of selected references on

transracial adoptions—David C. Anderson has written a sensitive and insightful book, *Children of Special Value,* from the viewpoint and experiences of white adopting parents. The journalist author and his wife have themselves adopted three children across racial lines. He tells the story of four families who between them have adopted ten such children. Racially these were black, American Indian, part black and part Indian, part black and part white, and Korean.

These highly personal stories provide a vivid, real-life picture, in which parents and children emerge as the differentiated individuals they actually are. Anderson writes about some of the influences leading up to such couples' decisions to adopt across racial lines, the reactions of their families and friends, their difficulties and their successes. He also reports on the different ways in which a strong sense of parenthood came into being for these mothers and fathers—sometimes quickly, sometimes gradually, yet influenced by how they felt about their particular child's characteristics and his ways of responding to them.

Anderson recognizes that interracial adoption is not for everyone, and that adopting parents will vary as to how well they raise their children for reasons that may or may not have to do with race. He is convinced that "adoptive parents develop a sense of parenthood for their children every bit as strong as that of biological parents, perhaps because the growth of any

parent-child relationship depends far more on the behavior of the human beings involved than on biology."

As the title of his book conveys, Anderson sees the blackness and brownness of these children not as liabilities, but as assets for the white families who adopt them. As "children of special value" they make possible for their parents a human insight only rarely acquired by "conventional" parents. Parental perception of such children's special value, he believes, makes all the problems to be expected in raising them more manageable.

Other Children with Special Problems

Of course, the same child may be in several hard-to-place categories at once: he may be nonwhite, no longer an infant, and handicapped—physically, emotionally, or intellectually. In order to evaluate the adoption of older children per se, Kadushin followed up 91 families who had adopted white healthy children between five and eleven years old. When adoptive outcomes were assessed on the basis of overall parental satisfaction, it was found that between 82 and 87 per cent were successful.

Clinical rather than statistical approaches, however, that have focused directly upon the older adoptive child have delineated certain psychological factors that agencies need to take into account in order to prevent and reduce problems for both the child and parents. This requires that agencies apply

psychodynamic insight to their procedures and services before, during, and after placement, as well as following legal adoption.

Sometimes, for instance, between placement and legal adoption these children may suffer an unconscious conflict of which their new parents, and the agency workers, too, are unaware; in recognizing it case workers could obviate parent-child misunderstandings and the problems to which these may lead. One example of such conflict is between the child's overt fear that he *will not* be legally adopted and his simultaneous fear that he *will.* Already hypersensitive to rejection as a result of the experiences that made him adoptable, he is in terror lest his new family decide against keeping him "forever." This makes it all the more vital, he feels, to conceal his opposite fear both from them and from himself: that the finality of being legally merged into this new family unit—emotionally and often socioculturally strange to him—will dissolve his sense of continuity with himself and his past, and thus destroy his internalized attachments to previous parent figures. As a general principle, instead of older children *being adopted,* they and their parents really need to *adopt each other.*

Increasingly, as agency policies have changed, and more adoptive applicants have been willing to assume the risks of parenting *children with various medical impairments*, such children, once thought to be unadoptable, have been placed. Study data have provided evidence that permanent

placement of these youngsters should not be delayed until medical prognosis has been established or corrective treatment begun, since this "can inflict irreparable damage to mental health." The same study stresses the importance of subsidies, when required, so that the prospect of costly medical payments need not deter the permanent placement of some of these children.

Adoptive parents are also now being found for *mentally retarded children* when the degree of retardation is mild, and when the child is thought to be able to fit into family life and to become self-supporting. In discussing factors to be considered in effecting such adoptions, Gallagher states: "For many children, mental retardation is a dynamic rather than a static condition, subject to change as the environment changes." That adoptive experience may, indeed, have a secondary as well as a tertiary preventive effect on some retarded children is borne out by a long-term follow-up study by Skeels.

Single-Parent Adoptions

Under certain circumstances some agencies have been departing from traditional practice in recent years by arranging single-parent adoptions. This represents one further way of increasing the number of permanent homes for children who would otherwise face long-term foster care "careers." So far such placements are made infrequently and only when no suitable two-parent family can be found, because of a child's special needs. In practice

nowadays these “special needs” usually mean that the child is black and of school age, or close to it. Despite its relative infrequency, however, single-parent adoption has aroused a great deal of interest among professionals because of its many implications for theories of child development and for principles of practice, as well as among the general public, in response to the attention given to this innovation by the news media.

Psychoanalytic case studies are the most intensive and detailed mode of psychological investigation on this question. Neubauer reviewed the ten case reports in the literature— and presented one of his own—in which the absence of one parent had taken place before or during the oedipal phase. This was found to cause “oedipal deficiency,” which, in turn, was related to the child’s pathological and social development. Unlike children who had never known a father relationship and were then adopted by a single woman, the small sample of patients reported by Neubauer *had* experienced some relationship with the parent with whom they had lost partial or total contact in their early years.

As against such microscopic perspective is the awareness that from six to nine million children are currently growing up in one- parent homes in this country. A disproportionate number of these families, for the most part headed by women, are poor; of these a disproportionate number are black. Herzog and Sudia have noted a widespread tendency to regard the one-

parent family as a sick family, a nonfamily, or an unfamily—a tendency that affects the children adversely. The fact that one-parent families include millions of children and have produced many effective and apparently happy adults warrants, they believe, "recognition of the one-parent family as a family form in its own right—not a preferred form, but one which exists and functions. . . ." For single women who want to adopt, agency criteria are being formulated; especially careful exploration of such applicants' motives to adopt is indicated.

It is still too early to evaluate the outcomes of such adoptions in any systematic way. Nevertheless, it is now being pondered whether it may not be preferable, from the mental health standpoint, to place older black children, for whom two-parent black homes are still too scarce, with single black women rather than with white couples. The outlook for transracial adoption, in terms of its emotional assets and drawbacks, would seem to hinge on the future course of the black movement. If the present vehement opposition to such adoption by some black groups and professionals becomes ascendant, adoption policy may favor intra-racial, single-parent adoptions over transracial ones as less stressful alternatives for hard-to-place black children.

Adoptive Outcomes

In the foregoing pages adoption has been viewed as a means of preventing maladjustment and of strengthening the mental health potential of children at special risk. Although evidence in support of these basic hypotheses has been interspersed throughout the discussion, it seems worthwhile to consider further, however briefly, some of the research findings on adoptive outcomes and adoptee adjustment. We ask of this research two kinds of questions about adoption in relation to prevention. First, given the fact that adoption does prevent physical and legal homelessness for children, to what extent does it succeed or fail psychologically as a form of positive family experience? Second, can adoption provide a context for reinforcing a child's potential for healthy maturation, and if so, how can adoptive services increase such a prospect? Or is adoptive experience per se, because of certain built-in factors, conducive to psychopathology for adoptees (as suggested by some psychiatrists and refuted by others, including this author)? If so, how can adoptive service reduce such risk?

Because follow-up studies of adoptive outcome vary so greatly as to methodology, sampling, degree of complexity, outcome criteria, and general level of research sophistication, findings from particular studies are far from comparable. In overall terms, however, the results of all these studies, taken

together, do confirm the preventive value of adoption for children who lack homes and who have often experienced antecedent deprivation. Thus Kadushin tabulated 14 adoptive outcome studies that had been reported between 1924 and 1968 under the following headings: size of study group and lapse of time between placement and study; number and percentages of subjects in each outcome category; the outcome criteria used for categorization (good, questionable, poor, and so forth); data used for follow-up assessment (interviews with adoptive children, adoptive parents, case records, and the like); and nature of the adoption being studied, whether agency or independent. In totaling these reported results, he found that 2,236 adoptees had been followed up; the adjustment of 74 per cent of these had been rated as unequivocally successful, 11 per cent as fairly successful or intermediate, and 15 per cent as unsatisfactory. Obviously many significant variables are washed out in this form of tabulation; nor can it do justice to the richness and complexity of the data or to the interpretations of their pertinence for practice.[8]

The research just referred to has been conducted by psychologists, social workers, and sociologists, singly or in teams, but without any direct participation by psychiatrists or psychoanalysts. Indeed, our contributions to the literature on adoption have mainly reflected our specialized concern and expertise with psychopathology.

Questions of Adoption and Emotional Disturbance

One major form of psychiatric and psychoanalytic contribution has been through reports of intensive case studies of emotionally disturbed adopted children and their parents. Such reports have been valuable for deepening understanding about psychodynamics and adoption-connected problems, such as have been found among these troubled individuals with at least some degree of regularity. Psychological data from disturbed members of adoptive families, however, cannot validly be assumed to apply *in toto* to that great number of well-adjusted adoptive families to whom clinicians generally lack access. The tendency to commit this error, some of us think, accounts in part for the conclusions reached by some clinicians—and challenged by others—that adoptive status per se has primary causal significance for child maladjustment, and that such risk is heightened if children who were placed as infants are told about their adoption before they have reached the latency phase of development.

In addition to case reports, the psychiatric literature on adoption of the past dozen years or so has consisted mainly of studies comparing the rates of emotional disturbance, and its symptomatology, of adopted and nonadopted children in the case loads of clinical settings. Much of the impetus for this series of investigations came from a 1960 paper by Schechter, in which he reported that about 13 per cent of the 120 children he had seen in private

practice over a six-year span had been adoptees (EFA); he concluded that "this indicates a hundredfold increase of patients in this category . . . compared with what could be expected in the general (child) population."

Schechter attributed much of this adoptee pathology to the fact that these children were told about their adoption when they were between the ages of three and six. Such telling, he believed, leads to various problems of superego and ego ideal formation. Thus, to learn that they really do have dual parentage —by birth and by adoption—at an age when children still tend to fantasize two sets of parents, one "good" and one "bad," prevents adoptees from the subsequent normal fusing (so Schechter thinks) of the split between parental images. Information about adoption should therefore be postponed until after the conflictual oedipal phase of development. Postponement would also spare the child, thought Schechter, from the narcissistic injury and anxiety that would come from his learning, before his ego was mature enough to cope with such knowledge, that he had been "rejected" by his original parents. Similar warnings about early "telling" were advanced by Peller soon after the Schechter article appeared. Agencies, by contrast, in consultation with psychiatrists, had been advising parents to begin explaining the child's adoption to him very early—almost as soon as he understood language. This advice has been predicated on the awareness that such communication entails a gradual process over time, not a one-time event, and must therefore be sensitively attuned, in terms of content, to the growing child's emotional

level and stage of comprehension.

Schechter's article was given wide publicity by mass media versions of its content, under headlines such as "The Truth Hurt Our Adopted Daughter" and "Why So Many Adoptions Fail." Understandably such "revelations" were extremely anxiety-arousing for adoptive family members, for child welfare workers, for natural parents considering surrender, and for prospective adoptive parents. There is no way of knowing how many children in need of homes were denied them because of the deterring effect on potential adopters of these articles. If adoption has, indeed, been discovered to be pathogenic and the early revealing of it to children a cause of maladjustment, then it would, of course, be necessary to effect appropriate changes in the light of this knowledge. If it has not, however, then the undermining of professional and public confidence in the primarily preventive value of adoption may be viewed as a calamity from the standpoint of public health and social policy.

Controversies among professionals that were set off by these initial articles have continued. In trying to resolve them, a succession of studies have been carried out. Although none of these—including a second by Schechter, in collaboration with Carlson, *et al*.—showed as high a percentage of adoptees among children referred for treatment as Schechter had first reported, they have confirmed the fact that EFA children are overrepresented to some extent

in clinical settings.

Granted the agreement now that a disproportionate number of adopted children have appeared at clinical facilities, there is still wide disagreement about why this occurs and what its significance is. A number of investigators have shared the view of Schechter and his co-workers that it is the factors, inherent in adoption that render adoptees more liable than other children to emotional disorder; another array of researchers, whose interpretations of the evidence seem far more convincing to me, do not regard the overrepresentation at clinics as a reliable indicator of the true incidence of adoptee disturbance. We also challenge the appropriateness of the comparison groups and the accuracy of the base rates that were used in reaching such conclusions.

A number of psychiatrists who have stressed that the rate of disturbance is greater for adopted than for nonadopted children have also described the adoptee patients as showing more aggressive and sexual symptomatology than nonadopted clinic children. Again the tendency among psychiatrists to apply findings from patients to nonpatients has helped to create the impression that adopted children characteristically manifest aggressive and sexual behavior problems. Evidence to the contrary has been provided by studies that compare the adjustment of adopted and nonadopted children from nonclinic populations.

Mikawa and Boston, for instance, studied two groups of "normal" children—20 of them had been adopted by nonrelatives and 20 were living with their parents; they found no significant differences between the adopted and nonadopted groups. From among other studies with similar results, that by Witmer, Herzog, *et al.™* is unusually rigorous and comprehensive. A sample of 500 adoptions studied ten years after placement were matched with a control group of nonadoptive children. Very little difference was found between the adopted children and their schoolmate controls, in terms of social and emotional adjustment.

In taking issue with the type of incidence and prevalence studies discussed earlier, I do not mean to deny that adoptive children and parents are subject to special psychological strains, which we as mental health professionals need to recognize and help to mitigate. It is just that it seems regrettable that so much of the available psychiatric time and effort has had to be deflected from needed study of urgent questions about adoption by repeated testing of the issues that Schechter first raised—especially since I, at least, do not regard the general population of children who live with their own families as an appropriate control group for assessing the psychological wellbeing of adopted children.

To illustrate how studies of certain kinds of adoptee problems, however, can point to ways of preventing them, several investigations have found that a

disquieting number of adopted children show some degree of cerebral damage. This seems, in large part, referable to the prenatal period, and to the infrequency with which the natural mothers of these children obtained prenatal care before the final months of pregnancy, if at all. In order, therefore, to help prevent reproductive casualty among adoptees, provision of prenatal services attuned to the needs of unwed pregnant girls and women, though not directly a function of adoptive services, is relevant to preventing some of the neuropsychiatric problems that afflict adoptees. A comparable preventive effort is being made by informing adoption workers more fully about medical genetics, insofar as this knowledge can be applied to the field of adoption.[9]

Now that agencies have corrected their earlier policy of severing contact with adoptive couples and children after legal adoption, they can far better help to prevent and reduce the psychological problems that do, of course, arise. One area, for example, of helping adoptive parents stems from our recognition nowadays that it is the acknowledgment and acceptance of the differences between adoptive and other family forms, rather than their denial, that is the more conducive to successful adoptive experience. Kirk has elaborated on this issue in his book *Shared Fate.*

Earlier mention was made about Schechter's and Peller's advice, on theoretical grounds, to postpone the "telling" of adoption until children had

passed through the oedipal phase. Many of us have found that parental anxieties in facing the facts of adoptive differences are especially likely to be mobilized around the questions of whether, what, and when to tell their children about their adopted status. In postadoptive counseling of parents, for instance, this has proven to be one of the most regularly recurring sources of concern and uncertainty; it is also one on which the interactions of group process can exercise a very beneficial effect.

Side by side with their genuine wish to protect the child from psychological harm and insecurity, parents often reveal an unconscious displacement of their own conflicts about adoption onto the more ego-acceptable fear of hurting the child emotionally by such disclosure. For parents with unresolved problems about their infertility, for instance, telling may mean exposing themselves as inadequate. For others an unrealistic sense of guilt—as if they had stolen the baby from its mother, or somehow did not feel entitled to be its parents—may underlie their discomfort in revealing his adoption to the child. Many parents, too, seem to fear that once their youngster learns he was adopted, he will stop loving them as much and wish for his original parents instead.

Most parents agree, intellectually at least, with the consensus of adoption experts—namely, that children do need to know that they were adopted and to learn that fact from their adoptive parents. To find it out from

others or by accident—as is almost certain to occur at some point—can be extremely traumatic for the child and can also seriously impair parent-child relationships. With regard to the controversy among professionals stimulated by the arguments advanced by Schechter and Peller, a number of us feel that the disadvantages of postponement outweigh the advantages, at least for the majority of children who are not emotionally disturbed.

Of course, just how one defines the essential nature of parenthood has much to do with the kind of meaning that one gives to what the adoptive parents are really "telling." From an experiential point of view, they can justifiably feel and convey that they are their child's true parents, not only by law, but also by virtue of their parental role behavior and relationship ever since his adoption. According to a widely held biological orientation, however, they are informing him that the unknown beings who gave him birth are by virtue of that fact alone "more really" his parents than they themselves are—a troubling situation, indeed, for adoptive parents and children to have to live with.

Krugman, in commenting on the biological orientation of both Schechter and Peller with regard to this question of where real parenthood lies, has noted the frequency with which, in his initial article, Schechter used the words "real" and "own" in connection with the biological parents, while neither adjective was used at all with the adoptive parents. She challenges

these authors' assumptions that children who are adopted as infants do, in actual fact, have two sets of parents—the first, and more "real," set having rejected them— and that for children to learn about this, especially in early childhood, is a critical determinant of psychopathology.

In contrast to the case material presented by these and other therapists from adoptees as patients, Krugman reports on her experience, as consulting psychologist to an agency, in appraising the development of over 50 children who had *not* been referred because of problems in themselves or their families. They had been placed for adoption as infants, were between three and seven when studied, and had all been told about their adoption before she saw them. She could find no evidence of parental image diffusion or of any other distinguishing "signs" of adoptive living among them.

As we seek to improve the psychological understanding of adoption, it would, indeed, seem that we, as psychiatrists, cannot mainly rely on our customary problem-focused approaches—at least with regard to the large majority of adoptive family members who are not emotionally disturbed. A range of services, based on such understanding, does have potential for preventing and mitigating the effects, for adoptive parents and children, of the special stresses and strains entailed in adoptive family process. But the central reality of adoption is its power to prevent the misery and maldevelopment of children who lack homes of their own. From that

perspective adoption is a repair of trauma, not a trauma in itself (except for unsuitable placements); it is not a losing or a taking away of what never was, but a mutual giving and gaining of affirmative family relationship.

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Notes

[1] This work deals only with the adoption of children by nonrelatives; almost half of the adoptions in this country each year are by stepparents or other relatives. The former are sometimes referred to in the literature as extrafamilial adoptions (EFA).

[2] It should be noted that for convenience the single term "adoption" is used throughout this chapter to refer to any or all of its several meanings: a form of personal family experience; a social institution based on law; a specialized area of professional service and of investigation.

[3] Because of its recognized leadership role in the effort to improve adoptive service, the Child Welfare League of America should be known to anyone interested in the field of adoption. This footnote is by way of introducing it to those non-social worker readers who may not already be acquainted with it.

The League is a privately supported national organization with an accredited membership of over 300 member agencies that provide care and services for deprived, neglected, and dependent children. Its activities cover the entire child welfare field, of which adoption service is a part. As one of its range of services, the League develops and publishes standards, with continual updating, that are generally regarded as authoritative, for example, *Standards for Adoption Service* (revised in 1968).In the form of monographs and books, as well as articles in its monthly journal, *Child Welfare,* the League's publications on adoption form an important part of the literature on that subject (several of its titles are included in this chapter's bibliography). It also sponsors research and conferences on adoption, and initiates special projects such as ARENA—the Adoption Resource Exchange of North America. As a totality the League has been a force, in the public as well as the voluntary agency sector, for positive change on behalf of children.

[4] For some of the more up-to-date reviews in the social service literature of these changing trends, the reader is referred to the Child Welfare League's 1968 revision of *Standards for Adoption Service*, as well as to overview articles by Chevlin, Kadushin, and Mech.

[5] I am participating in a prospective longitudinal study of adoption in infants that may shed some light on this issue. It is in process at the Child Development Center, New York City, under

the direction of Dr. Peter B. Neubauer:

[6] It is now generally recommended that statewide adoption resource exchanges be set up in order to increase the opportunities for both children and adoptive applicants. These exchanges, in turn, should work through ARENA, the Adoption Resources Exchange of North America, which has already been established by the Child Welfare League of America. Also at the international level recommendations for improving intercountry laws and practices were made by the 1971 First World Conference on Adoption and Foster Placements.

[7] Under certain conditions some single individuals are also now being approved as adoptive parents.

[8] Several of the more outstanding investigations of adoptive outcome, covering a range of methodologies that help to supplement each other, are listed in the Bibliography at the end of this chapter.

[9] Such application of knowledge from other fields to our topic exemplifies the reciprocal relationship that exists between adoptive concepts and practices, on the one hand, and the research uses of adoption for investigating broader basic issues, on the other. Psychiatric consultants to adoptive agencies can perform a useful function by extracting and integrating pertinent findings from each of these different but mutually supplementary research approaches, for application to agency policies and procedures.