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Understanding and Treating Adoptive Families

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Mental health professionals who provide clinical services for children and/or families frequently receive referrals to work with adopted children and their parents. In fact, research has shown that adoptive families are two to five times more likely to utilize outpatient mental health services than are non-adoptive families (Howard, Smith & Ryan, 2004; Keyes, Sharma, Elkins, Iacono, & McGue, 2008). Although elevated referral rates reflect, in part, a tendency by adoptive parents to more quickly utilize mental health services than non-adoptive parents, they also indicate a higher risk of psychological and academic problems among this population of children (see Harwood, Feng, & Yu, 2013; Juffer & IJzendoorn, 2005; Smith, 2010 for reviews of this literature).

The reasons underlying increased adjustment risk for adopted children and their families are complex and reflect both pre-adoption factors (e.g., genetics, prenatal complications, and pre-placement adversity such as neglect, abuse, multiple foster placements, and/or orphanage life) and post-adoption factors (e.g., quality of care provided by adoptive parents, including the way they manage the normative challenges related to raising adopted children) (Brodzinsky, 2013; Smith, 2010). As a result, when families present for clinical services, mental health professionals must be prepared to assess and understand a myriad of factors that potentially have impacted children and parents and compromised their capacity for effective coping. This task is all the more complicated today (as noted in the previous chapter by Pinderhughes and her colleagues) because of the different ways in which adoptive families are formed, leading to vastly different family life experiences.

To more effectively meet the clinical needs of adopted children and their parents, the present chapter highlights assessment issues and intervention strategies that are helpful in addressing some of the unique adoption-related factors that are likely to be found in this clinical population, especially those related to loss, stigma, rejection, and identity. The goal of the chapter is not to prescribe a specific way of working with all adoptive families, but rather to help clinicians integrate an "adoption perspective" into a more comprehensive approach to understanding and intervening with their clients. Along the way, I will make specific comments about the case study raised in the previous chapter by Pinderhughes[1].

On the Need for Adoption Sensitivity Among Mental Health Professionals

It is widely accepted in the adoption field that placement stability, healthy child outcomes, and parents' satisfaction with their adoption decision are tied to good preparation prior to adoptive placement and with the availability and utilization of effective supports and services, including mental health counseling, in the post-adoption period (Brodzinsky, 2008; Smith, 2010; Tarren-Sweeney & Vetere, 2013). Finding an adoption-competent therapist is often high on the list of services sought by adoptive families, but too frequently efforts to locate such a professional are unsuccessful (Atkinson, Gonet, Freundlich & Riley, 2013). In fact, adoptive parents and adult adopted individuals sometimes report that the advice, guidance, and actions of professionals have not only been unhelpful, but sometimes damaging to themselves and their families (Casey Family Services, 2003; Festinger, 2006, Smith & Howard, 1999; Tarren-Sweeney, 2010). Examples of the problems experienced by some adoptive kinship members in working with mental health professionals include: having their experiences disbelieved or

[1] In addition to commenting on this case study, as requested by the book editors, I will periodically describe clinical cases from my own practice. All names and contextual details in these cases have been altered to protect clients' confidentiality.

denigrated; being blamed for their children's problems; having adoption and/or their family pathologized by the therapist; having their motives for adoption questioned, including their decision to adopt a specific type of child (e.g., one with known special needs); being advised not to talk about adoption with their children because it will "stir things up"; not being asked about children's pre-adoption history or addressing the impact of previous trauma during treatment; not being asked about the impact of adoption issues on family members or addressing their impact during interventions; and having therapists use ineffective intervention strategies for children with specific types of psychological problems (e.g., seeing children with attachment disorders individually, without parental involvement in the treatment process).

There are many reasons why members of the adoptive kinship system have difficulties in accessing adoption-competent therapists (see Brodzinsky, 2013 for a more detailed discussion of this issue), but the bottom line is that far too few mental health professionals receive adequate training in working clinically with this population. For this reason, there is a growing consensus in the adoption field for the need for post-graduate, adoption clinical training for mental health professionals (Atkinson et al., 2013; Brodzinsky, 2013; Tarren-Sweeney, 2010; Tarren-Sweeney & Vetere, 2013). For a more detailed description of what constitutes adoption-clinical competence and the different pathways for achieving this goal, see Brodzinsky (2013). The remainder of this chapter will focus on one aspect of adoption-clinical competence; specifically, integrating adoption issues into a broader assessment and intervention model. Before addressing this issue, however, a few words about the importance of maintaining a developmental, systemic and ecological perspective are in order.

Adoption from a Developmental, Multisystemic and Ecological Perspective

Mental health practitioners come from many disciplines, are exposed to many theoretical models, and utilize a range of assessment and intervention strategies. Given the complexity of adoptive family life today, it is clear that no one intervention technique, no matter how well-validated by research, will be sufficient to meet the mental health needs of these families. Therapists need to be skilled in a wide range of treatment strategies, but also to have a clear understanding of the limits of their competence and be prepared to make a referral to another professional when the clients' problems are beyond their scope of expertise.

In my experience, successful therapeutic work with adoptive families is supported by maintaining a developmental, multisystemic and ecological perspective of the factors impacting family members. All families are embedded within a complex ecological system and are impacted in a myriad of ways by the network of subsystems that make up their daily lives (Bronfenbrenner, 2005). Furthermore, systemic influences change over time, in response to the developmental and family life cycle needs of children and the family as a whole. Adoptive parents and their children, however, are likely to be actively involved with a greater number of systems external to their family than are others (Brodzinsky, 2013; Palacios, 2009).

The pathway to adoptive parenthood is varied, complicated and often stressful. It often involves years of medical interventions to address issues of infertility. Once adoption is chosen as the means of achieving parenthood, legal and social work systems come into play. Only adoptive parents (and foster parents) have to prove their suitability to others before being allowed to raise children; and even after being found suitable for adoptive parenthood, they depend upon adoption and legal professionals to facilitate this process. Furthermore, in private

domestic adoptions, birthparents often choose the family who will adopt their child, making adoptive parents dependent upon yet another person's decision in their efforts to achieve parenthood. In short, the transition to adoptive parenthood is fraught with barriers and requires prospective parents to engage multiple people, organizations, and systems in order to achieve their goal. In many cases, these experiences create heightened anxiety and uncertainty in parents and can negatively impact their ability to manage adoption-related responsibilities in the years to come (Brodzinsky, 1997; Brodzinsky & Pinderhughes, 2002).

Involvement with multiple systems continues after adoption placement. A growing number of children who are adopted today are older at the time of placement and have experienced prenatal complications (e.g., alcohol and drug exposure; heightened prenatal stress) and early life adversity (e.g., neglect, abuse, multiple foster placements, orphanage life), which in turn, increases the risk for medical, neurological, psychological, emotional, relational, behavioral, and educational problems. As a result, adoptive parents and their children are frequently actively involved with medical professionals, mental health professionals, child welfare professionals, and special education professionals in their efforts to prevent or minimize the impact of the pre-placement adverse risks and to facilitate healthy development and adjustment of all family members. In addition, more and more adoptive families are involved in open placements with one or more members of the birth family, requiring yet another set of challenges in managing relationships with another family system.

The picture that emerges of adoptive families is one of dynamic engagement with and dependence upon multiple systems in their lives. Therapists who engage the individual child and/or the family as an isolated unit, without an appreciation for the ecology of adoptive family life, will miss important information about past and current factors that impact the health and

well-being of their clients. In short, to be effective in working with adoptive kinship members -- that is, to be adoption-clinically competent (Atkinson et al., 2013; Brodzinsky, 2013) -- therapists must consider the potential influence of developmental, contextual and systemic factors in the lives of their clients and how the unique experiences of being adopted and raising adopted children can be addressed in therapeutic interventions.

Assessing Family Life Cycle Issues in Adoption

When taking a developmental and family history, it is important for therapists to examine different family life cycle issues that are unique to adoption and to integrate the information into a comprehensive picture of their clients and an informed intervention plan (Brodzinsky, Smith & Brodzinsky, 1998).

Exploring parents' motives for adoption, including the impact of infertility and previous child loss through miscarriage, abortion, and death, will help the clinician better understand their clients' readiness to address issues of loss and stigma, not only in their own lives but in the lives of their adopted children (Brodzinsky, 1997; 2011). When parents have difficulty resolving their own losses, it compromises their ability to be sensitive to and support their children's efforts to cope with adoption-related loss.

Questions addressing how the decision to adopt was made by the parents, the reasons for pursuing a specific type of adoption (e.g., child welfare placement, private domestic placement, intercountry placement) or a specific type of child (e.g., infant or older child, healthy or special needs child, same-race or different-race child), the extent of support for adoption from extended family and friends, and the parents' experiences in working with the adoption agency during the home study process will be useful in assessing the level of stress parents experienced during the

transition to adoptive parenthood and the extent and effectiveness of the support offered by others. These issues are critical in helping parents develop realistic expectations about adoption, a key factor in post-adoption family adjustment. So too is gathering information about what parents were told about their child's pre-placement history and their understanding of the potential impact of that history on parenting and child development.

Integrating an adopted child into a family is a gradual process, and often a complicated one, especially when the child is beyond the infancy years at the time of placement (Pinderhughes, 1996). Examining the success with which parents have fostered secure parent-child attachment is a critical part of the assessment process. Children placed from foster care, such as James in the clinical vignette presented by Pinderhughes, as well as those adopted from abroad, often display difficulties in forming a secure and healthy attachment to their parents. Helping parents become more emotionally attuned to their children's unique needs and reframing their children's challenging behaviors (e.g., difficulty being comforted, clinging, indiscriminate friendliness, hoarding food and other objects) in terms of adaptations to previous deprivation, trauma, and relationship disruptions, can be reassuring to parents and foster hope in their ability to support developmental recovery.

James' adoption raises another important issue that needs to be assessed by clinicians; namely, parents' attitudes, expectations, and actions related to raising a child of another race. Transracial adoption, as Pinderhughes notes, is quite common in the U.S. Although research indicates that outcomes for transracially adopted children are generally similar to those in same-race families (Smith, McRoy, Freundlich, & Kroll, 2008), complications can arise, especially in terms of children's self-esteem, racial pride, and racial identity, unless parents receive adequate preparation and support regarding racial socialization. When working with transracial adoptive

families clinicians need to explore the parents' expectations about raising a child of another race, the support for such an adoption within their extended family, and the steps they have taken (or plan to take) to support their child's racial pride and identity. In the case of the Filen family, we see that the parents recognized the value of joining a predominantly African American church and that their decision was helpful in fostering racial pride in their son. What other steps they took to support their son's connection to his racial and cultural heritage is unknown, but certainly relevant for understanding family dynamics and James' adjustment. Clinicians must recognize that the process of facilitating racial socialization in different-race adoptive families is a complicated one and that parents vary widely in their attitudes about its importance and in the actions they take in support of their children's racial identity. This area of family life deserves careful and thorough consideration in the assessment process and in treatment planning. Clinicians also need to be aware that this is an area in which parents are often naive about their children's perspective of living in a different-race family. It is extremely common for children and youth to keep their uncertainties, discomfort, and feelings of differentness a secret from their parents. Exploring this issue separately with children, as well as the broader issue of their feelings about being adopted, may lead to a recognition that there is much about the children's emotional life that is unknown to their adoptive parents. Undoubtedly, this is the case with James and his parents.

Exploring the extent of contact with birth family and the nature of that contact is also an important assessment goal. In many cases, contact can be quite supportive for adopted children; in other cases, it may be disruptive. Such was case for James. As a foster child, he had regular supervised visits with his birth mother but was often destabilized by contact because of her ongoing emotional and addiction problems. When his adoption was eventually finalized, all

contact between James and his birth mother ended. What did not end, however, was his curiosity about her. He continued to think about and long for her, but he also sensed that his adoptive parents were uncomfortable discussing this topic; so he remained silent. This family dynamic is all too common in adoptive families and raises another critical assessment issue -- the extent that adoption issues are openly and honestly discussed in the family.

Pinderhughes and her colleagues describe an important distinction regarding openness in adoption (see also Brodzinsky, 2005). Structural openness refers to the extent of contact between adoptive and birth family members. As already noted, such contact can be quite beneficial for adopted children and youth, as well as their adoptive parents and birth parents, although this is not always the case. Communicative openness, on the other hand, refers to the ability of family members to share their thoughts and feelings about adoption with one another in an honest, non-defensive and transparent way. Research indicates that communicative openness is a more powerful predictor of children's adjustment than structural openness (Brodzinsky, 2006). This finding, as well as other research on the importance of communicative openness described by Pinderhughes, reinforces the value of clinicians exploring when, how, and under what circumstances family members discuss adoption issues. Too often, adoptive parents treat the sharing of adoption information as an event rather than as an ongoing process. Too often, if their children no longer ask questions about their heritage and the circumstances of their adoption, parents believe that their curiosity and "need to know" has been satisfied. In most cases, as we see with James, nothing could be further from the truth. In my clinical experience, one of the most important assessment goals is understanding the extent of adoption communication in the family and the barriers that may inhibit greater openness and honesty. This process includes identifying the information that parents find "too difficult" to share and

exploring the reasons for their reluctance to share it. In the case of James, it appears that his adoptive parents did not know how to explain the birth mother's problems to him and so chose to remain silent, leaving their son to fill the informational void with his own fantasies. Clinical work with adoptive parents often involves helping them reframe "difficult" information related to their child's past in terms of age appropriate, supportive, and respectful messages about the birth family and the circumstances of the adoption. Such messages help children cope with the realities of their life, including the losses they have experienced (Brodzinsky, 2011), and, at the same time, reinforce their connection to the birth family in a respectful manner. James' adoptive parents might have helped him to understand that his birth mother had a serious illness -- one that could not be easily resolved -- that made it impossible for her to care for him, as she clearly wanted to do. Although she loved him and did her best to meet his needs, eventually, but reluctantly, she understood that he needed a more stable and nurturing family. In short, the decision to allow him to be adopted was a difficult one for her, but one she made out of love for him.

Many adoptions, such as the one characterizing the Filen family, are closed. But closed adoptions do not necessarily remain closed over time. The need for information about one's origin, and/or contact with birth family, is viewed as a normal process by adoption professionals, a part of the universal search for self (Brodzinsky, Schechter & Henig, 1992). More and more adopted persons and birth family members are searching for one another. Moreover, in the age of the internet, a growing number of families are experiencing what the Filen family did; namely, their adolescent has taken it upon him/herself, without informing parents, to make contact with one or more members of the birth family through social media. Such contact often creates anxiety for parents and sometimes rifts in parent-child relationships. The adoption field is only

beginning to understand the benefits and drawbacks of the transformative impact of the internet on adoption practice and adoptive family life (Howard, 2012). Clinicians are likely to be asked for guidance by adoptive parents about supporting their child's search for information and/or contact with birth family. Exploring their attitudes about searching and what efforts, if any, have been made to find additional information about, or seek contact with, their child's birth family is an important part of the assessment process.

Finally, exploring the child's perspective of adoption is a key part of clinical assessment. As noted above, children often have different views about adoption than their parents. In their joy about building their family through adoption, parents often overlook or minimize the confusion, uncertainty, and emotional pain that children sometimes experience as they come to understand the realities of adoption and the implications of their previous life experiences. Exploring children's understanding of adoption, their feelings about not being raised within the birth family, their experience of connection and "fitting in" with their adoptive parents and siblings, their desire for information about birth family and the circumstances of their adoption, their reaction to contact with birth family (when this is part of their lives), and how adoption has impacted their sense of self and identity are relevant areas for assessment and treatment planning.

Interventions Targeting Adoption Loss and Identity

Adopted children and their families present clinically with a wide array of symptoms and relationship dynamics. Some problems are quite circumscribed and easily diagnosed within DSM-5. Other problems, especially those found in children with complex and adverse early life histories sometimes defy easy diagnoses (DeJong, 2010; Tarren-Sweeney & Vetere, 2013) and

are difficult to manage clinically. More and more children being adopted today experience early trauma and multiple relationship disruptions, leading to a host of thorny and confusing clinical symptoms. Often, their problems require specialized interventions targeting attachment issues and complex trauma symptoms. Fortunately, a number of evidence-based, evidence-informed, and promising practice interventions have been utilized successfully with adopted children and their families (see Brodzinsky, 2013 for a brief review of these interventions). In my clinical experience, however, there is often an overlay of complex loss and grief, independent of presenting clinical symptoms or interacting with them, that is overlooked by clinicians and that too frequently go untreated. In the remainder of the chapter, I would like to highlight several treatment strategies that adoption clinicians have found especially useful as adjunctive interventions with children and families. The common features of these interventions are their focus on: helping children understand what has happened to them; facilitating healthy connections to their origins (as well as their current family); creating greater communicative openness in the family; and supporting adaptive grieving related to adoption loss. Before describing these interventions, though, a few words are in order about adoption-related loss.

Adoption Loss

It is widely recognized among adoption professionals that loss and grief are core components of the psychological dynamics of adopted children (Brodzinsky & Pinderhughes, 2002; Leon, 2002; Nickman, 1985). Clinicians who do not regularly work with adopted children, however, often fail to recognize the pervasiveness of adoption-related loss (Brodzinsky, 2011). Adopted children not only lose their birth parents, but also birth siblings and extended birth family. In addition, they frequently lose relationships with previous non-biological caregivers and supports (e.g., foster parents, foster siblings, orphanage staff, teachers, coaches,

therapists, peers, neighbors) as they move from one foster home to another or from their country of origin to their current family. When they eventually recognize that most people view adoption as a "second-best" kinship connection compared to biological kinship, they also experience status loss or stigma. Moreover, dissimilarities from adoptive family members in genetic-based abilities, traits, and physical features often make children feel different, leading them to question whether they really "fit in" with the family. Many adopted youth also experience the loss of racial, cultural, and linguistic connections when their relationship with their birth family and culture of origin is cut off. And as they pass through adolescence and into adulthood, others struggle with identity issues, feeling that their authentic self has been lost.

Complicating the resolution of these many losses is the fact that they largely go unrecognized by others, including many adoptive parents. According to Doka (2002), when loss is unrecognized, ignored, minimized, or denigrated by others, the opportunity for healthy grieving is compromised, leading to what he called "disenfranchised grief," and the likelihood of increased emotional problems. Unless clinical interventions are designed to acknowledge and validate children's sense of loss and their uncertainties in identity, they will not be sufficiently effective to help these boys and girls in their emotional recovery.

Lifebooks

Lifebooks are, by far, the most common tool used by social workers to prepare children for family transition and adoption (Backhaus, 1984; Baynes, 2008; Johnson & Howard, 2008). Increasingly, they are also being used by clinicians as a means of helping children make sense of their lives and to facilitate thoughts and feelings about their experiences.

Lifebooks are symbolic representations of a child's life, frequently constructed in the form of a loose-leaf binder, with material arranged chronologically. Historically, social workers often created a lifebook for a child and passed it on to the adoptive family at the time of placement so that they would have information about the child's past, including pictures of birth family and other previous caregivers. As a clinical tool, however, lifebooks should be *co-constructed* with the child (and/or family), allowing the therapist the opportunity to process the meaning of specific material with the clients. What becomes part of the lifebook depends on the age of the child, the information available, and the readiness of the child to process specific issues in his/her life. When information about the past is unavailable, children are encouraged to share their fantasies, hopes, expectations, and fears in relation to the issue being discussed, which can then be incorporated into the lifebook in the appropriate chronological space. For example, over the past few years, I have been working with a nine year old girl, who I will call Tatiana, who was adopted from Russia at the age of four years. Although she has some memories of her time in the orphanage, including pictures of a few of her caretakers and other children who resided there, she has no memories and little factual information about her birth family. Through lifebook work, Tatiana has been able to explore her fantasies about her birth family, including what they look like (through drawings and written descriptions), what they do for a living, what their life might be like, whether she has any biological siblings, what their thoughts and feelings are about her, and what questions she might have for them should they one day meet. By going on the internet, we have also found pictures of the city she is from and the orphanage she lived in, as well as information about her culture of origin, which were then downloaded and incorporated into the lifebook.

Lifebook work helps children connect their past to their present life and to future hopes and desires. They bring order to the mystery and chaos that too often exits in the child's mental and emotional life. They provide opportunities for discussing children's memories, fantasies, wishes, uncertainties, and fears in the context of a safe and supportive environment. Importantly, they normalize and validate children's curiosity about their origins, promote a more realistic understanding of adoption, foster a more positive view of self, open up communication about adoption in the family, and support adaptive grieving.

Although a number of authors have published workbooks for creating lifebooks with children and their parents, I have found them too limiting and structured -- i.e., they promote starting at a specific point in the child's life (usually at birth) and progressing forward chronologically. But children's interests, desires, and needs do not follow a set chronological or consistent pattern and the issues they raise in family life and in therapy are not always covered in the workbooks. For example, sometimes it is difficult for children to talk about their birth family early in therapy, but easier to discuss their current life. In such cases, lifebook work begins by incorporating written and pictorial information about their adoptive family. As their comfort in talking about the past grows, information about their history, pictures of where they came from, pictures of their birth family and previous foster parents (if available), and thoughts and feelings about their birth family can then be incorporated into the lifebook. By using a loose-leaf binder, new information, documents, and children's work products can be placed in the appropriate chronological sequence -- with their past represented in the beginning of the lifebook, their current family life in the middle, and their hopes and expectations for the future at the end.

Lifebook work can be done individually with the child or in family sessions. Adoptive parents should be encouraged to gather as much information as is available about the child's birth

family and previous caregivers, the child's cultural heritage, and their adoption. Having parents re-contact the adoption agency, attorney, orphanage, and others who were involved in the adoption process often produces information that was never shared with them at the time of placement or new information that has since been forwarded to the agency by the birth family. In short, there are no limits about what can or should be included in a child's lifebook, including clinical material that comes up during sessions in which lifebook work is not specifically the focus of attention. As long as a child gives permission and is interested in incorporating some version of the session's content into the lifebook, it will not only enrich this work product but can also provide additional opportunities for processing clinically relevant information with the child. As an example, Tatiana has frequently raised issues about her birth mother at unexpected times during sessions when we were not involved in lifebook work. Often, she asks to include the substance of our discussion in the lifebook; at other times, I make the suggestion and she agrees. Consequently, her lifebook is filled with lists of questions she would like to ask her birth mother, possible first names of her birth mother, places she would like to visit with her birth mother, presents she would like to give to and receive from her, and so forth. Each list has become a goldmine of opportunities for exploring her beliefs, hopes, expectations, and fears about her past and its connection to her current and future life.

Therapeutic Rituals

The use of therapeutic rituals with individuals and families has a long tradition in mental health practice (Imber-Black & Roberts, 1998). Therapeutic rituals are symbolic acts, co-constructed with clients and are used for a variety of purposes, including giving meaning to celebrations, life transitions, new relationships, identity, and relationship losses. Rituals allow for the expression and containment of strong emotions and can promote emotional healing. They

also are a means of connecting the past to the present, and the present to the future. For a review of the nature of therapeutic rituals and how to create them with clients, see Imber-Black, Roberts and Whiting (1988), Imber-Black and Roberts (1998), and Lieberman and Bufferd (1999).

For some time now, clinicians have been using therapeutic rituals with adoptive families and adopted persons, as well as birth parents (Whiting, 1988; Lieberman & Bufferd, 1999). One example is an entrustment ceremony conducted at the time of transfer of the baby from the birth family to the adoptive family. The goal of the ceremony is to empower adoptive parents with the responsibility of raising their child, building connections between the birth family and adoptive family, and reinforcing the child's enduring connection to both families. Other common adoption-related rituals include candle lighting ceremonies, planting of flowers and other vegetation, and picture taking as a way of celebrating different aspects of adoption, strengthening adoptive family ties, remembering and validating children's connection to their birth family, and helping children cope with adoption-related loss. Consider, for example, Alicia, a 35 year old woman, who was seen by me individual therapy several years ago.

Alicia had been removed from her birth family by child protective services at the age of two years because of neglect and parental drug addiction and mental illness. Although she had some contact with her birth family through the age of eight years, eventually parental rights were terminated and she lost all subsequent contact with them. During the years of contact, she was frequently re-traumatized by her birth parents who visited her when they were intoxicated and emotionally destabilized. They often made unrealistic promises to her, scolded her for any affection shown to the foster parents, and threatened the foster parents. As she developed, Alicia became quite depressed, harboring deep resentment toward her birth parents. As an adult, she sought contact with them but was told they had died from drug overdose. Without any way of

resolving her deep-seated anger, her depression deepened. During therapy with me, we decided that she needed to find a way of externalizing her resentment and anger toward them, thereby allowing her to move forward in her life in a more productive manner. With some guidance, she wrote her birth parents a lengthy letter, describing her memories of contact with them and how they frightened her. She wrote of her disappointment in having parents who gave her life, but not love, nurturance, understanding, support, or feelings of safety. She wrote of her need to put aside her anger at them so that she could finally heal. Once the letter was written, we designed a ritual, that she wanted to share with me, in which she would describe her memories and feelings about of the past and then burn the letter and bury the ashes, thereby putting to rest her buried pain. Although the ritual, by itself, did not ameliorate Alicia's depression, it was a turning point in therapy and in her life, eventually leading to more positive feelings about herself and more satisfaction in her relationships with others.

Narrative Strategies

Narrative therapy, by itself, and in conjunction with other intervention strategies, has shown significant promise in working with children, adolescents, and adults who have experienced early life adversity, complex loss, and relationship disruptions, including those were adopted (Lacher, Nichols, & May, 2005; Vetere & Dowling, 2005). Based upon the belief that the "stories" people have internalized about themselves and their lives often restrict them from overcoming personal difficulties, narrative therapists seek to help people explore their memories, beliefs, expectations, hopes and worries. By eliciting clients' "stories" verbally, in written form, through pictures or by other means, clinicians help them reframe or "re-author" their life narratives, and find alternative ways of integrating past difficulties into their lives, identify and

support personal strengths, identify important support figures, and foster healthier relationships with others.

With children, narrative interventions are often done in the context of play, as stories are elicited from their drawings, doll house activities, puppet play, construction activities, and so on. At times, narrative work is done with children individually, but often, at least in my practice, it involves other family members too. Family-based narrative work has complications, however, not the least of which revolves around the questions of "whose story dominates," or "whose story should be the focus of attention?" (Dowling & Vetere, 2005). As a guiding principle, in my own practice, I make special effort to ensure that the voice of the child is paramount; that their story is not only elicited, but heard, respected, and reflected upon by others. This is especially important in working with adoptive families because so much of the inner life of children is unknown by their parents. Recognizing that their parents often have different views about their adoption and/or their birth family than they do, children frequently withhold their thoughts, feelings, concerns, worries, and desires about these issues for fear that what they may say would not be understood or well received. As one eight-year-old girl recently said to me, "If mommy knew how much I think about her [birth mother] it would just make her cry." When children are given a voice in therapy, when their narratives are the focus of concern, they are likely to feel safe and become more engaged in the treatment process. In turn, parents have the opportunity to more fully understand their child and be better prepared to meet their emotional needs.

With adolescents and adults who were adopted, narrative interventions are also valuable, although the vehicle for eliciting clients' stories usually is different. The use of journaling and letter writing are common ways that therapists facilitate self-reflection and exploration of troubling issues in their clients. A number of years ago, I developed a variation of the letter

writing technique that has been quite successful in my work with adopted teenagers and adults. In this written role play intervention, the client is asked to write a letter to someone of importance from the past -- usually a birth parent -- sharing whatever thoughts, feelings, questions, or information that he or she wishes. After completing the letter the client is asked [sometimes in the same session, sometimes later] to take the role of the other person and to write back as if they actually had received the letter and are responding to it. The client is encouraged to consider what the other person might think or feel about getting a letter from them and what questions they might raise in their responsive letter. Once the second letter is written, the client is then asked to write another letter to the identified person, responding to the letter they received. This back and forth "communication-with-the-self" can continue for as long as the client and therapist believes it is useful. Consider the following examples of letters written by Lauren, an 18 year old female who was adopted from China at the age of 13 months. [These letters were written in between sessions, but processed clinically during sessions.]

> *My therapist has asked me to write you a letter. I thought about doing so on my own for so many years, but just never got around to doing it. It's not because I haven't thought of you. In fact, not a week goes by when something doesn't remind me of you -- not you in particular, since I don't know you, but you in the abstract, my birth mother. I've lived my whole live feeling different from others around me, but they don't know my feelings. Perhaps they would understand if I told them, but I'm not sure and I've never given them that chance ...*
>
> *I look in the mirror each morning and wonder about who I look like and who I take after. I think about you and my birth father and wonder if I look like you, if you are also shy, if*

you had the opportunity to go to school like I did, or if you are poor and live on a small farm in the countryside. I wonder if you are even alive ....

I leave for college soon and it's a big step in my life and a scary one ... I'm supposed to be gaining independence, to be learning to live on my own, but I'm really scared. How can I be truly independent when I don't really feel that I know who I am. I sometimes feel hollow inside, like an Asian shell that was never filled and maybe never will be ...

In the following week, Lauren wrote a letter from her "birth mother" to herself.

Dear Lauren,

Your letter made me happy and sad at the same time. I was happy because I know you are alive and healthy and are going to college. I am happy that you have a family that loves you. But I'm sad because you seem so uncertain about yourself and believe that others don't know you. If you don't give them a chance to know you, then they can't really know you. I wish you didn't feel so different or at least didn't feel bad about being different ...

Several months later, Lauren wrote the following letter to her birth mother.

Dear Mom,

I recently saw a movie, a documentary, about a Chinese girl who was adopted and she went back to China and was able to find her birth family. I didn't know it was possible. I cried all through the movie. Things that she said and things that she felt were just what I've thought and felt. I didn't know others who were adopted felt that way I too. Well maybe I did but I've never talked to anyone about their feelings or mine. And when I saw

the movie and heard this young woman talk about her need to know about what happened to her and why she wasn't kept by her birth family, somehow everything that I've been feeling seem to make sense ...

I don't know if I'll ever be able to find you or others in my birth family, but I know one thing, I WILL TRY!

Search as Intervention

Increasingly, adoptive families are seeking guidance from professionals regarding the appropriateness and pragmatics of searching for birth family. Helping families with this decision and guiding them through the process can be a valuable intervention, opening up communication in the family, validating children's connections to their origins, supporting their identity, and facilitating healing in relation to adoption loss (Brodzinsky et al., 1998).

Clinical support for a decision to search by minor children and their parents should be based upon several considerations. First, searching should be based upon the child's need for, and readiness to accept, contact with the birth family, not the adoptive parents' needs. At a time when searching for origins has been normalized, adoptive parents sometimes believe that they must initiate a search as soon as possible, without considering whether their child is interested in contact or ready for it. Second, searching should not be viewed as an answer for treating troublesome problems in the adoptive family. It must be based upon emotional stability and relational security and trust in the family. Parent-child conflicts and adjustment difficulties in children seldom are resolved simply by making contact with birth family; in fact, they can be exacerbated by the additional stress and unrealistic expectations that accompany poorly planned searches. Third, searching should not begin until parents and children have had an opportunity

to explore, together and separately, their hopes, expectations, and concerns related to contact with birth family. Unrealistic expectations need to be discussed openly and worked through before searching begins. The possibility of not being able to find the birth family or having them be uninterested in contact with the adoptive family are possible realities that must be faced and integrated into plans for searching. Fourth, searching should proceed slowly, with appropriate "check-ins" to ensure that everyone is coping well with the process and are supportive of moving forward. It is not uncommon, for example, for teenagers to pressure their parents to begin the search process, but to show less interest in contact once the process has begun. In exploring the reasons for his diminished interest in making contact with his birth family, Sean, a 14 year old I recently worked with confided, "I guess I was mostly interested in knowing that they [adoptive parents] would really support me ... now that we've begun, I'm not sure that I'm ready to meet them [birth parents] ... maybe later when I'm older." Fifth, children should be actively involved in search plans. Although parents have the right and responsibility to control the search process, children need to feel as if their thoughts and feelings are being taken into consideration. When Sean's parents realized that he was not ready for contact, they put the process on hold, even though they were enthusiastic about continuing. Sixth, clinicians need to help families understand that searching often proceeds in an uneven manner, with interest being shown by youth at one time and disinterest in another. For the time being, Sean feels comfortable not proceeding with the search and his parents have supported his decision. Perhaps in a year or so, he may change his mind, at which time his parents will need to reconsider their options. Helping parents understand the normality of their children's contradictory feelings and actions in relation to searching and contact with birth family will minimize their frustrations as they are buffeted about by their children's mercurial moods and needs. Seventh, as information about the birth

family becomes known, it may become obvious that contact with them is not in the best interests of the child or the family. Clinicians need to be prepared to assist parents and children with this reality. Sara, 11 years old, and her parents had made contact with Sara's birth parents through the adoption agency that had made the placement and slowly got to know them through telephone calls and Skype sessions. With my help, a plan was made to visit the birth family during summer vacation. A few months before the trip, however, the adoptive father found out that the birth father had been arrested for possession of drugs and the birth mother was actively using drugs. Believing that contact with them was potentially dangerous for their daughter and themselves, they cancelled the trip. Although Sara was upset when told that she would not be meeting her birth parents at the present time, her mother and father were able to help her understand their decision in a way that did not denigrate the birth family or her connection to them. Furthermore, in the course of therapy, we developed a plan to continue telephone and Skype contact with the birth mother after she went through a drug program and to write letters to the birth father who had been imprisoned for drug possession.

Finally, in the age of the internet, adoptive parents must come to realize that they cannot fully control the search process. More and more adopted adolescents and adults are searching for birth relatives online, often with great success. Adoptive parents worry about the impact of contact with birth relatives through the internet, especially when they are "out of the search loop." James' parents (described by Pinderhughes) are not alone in being at odds regarding the best course of action -- i.e., whether to support contact or try to end it. If they had consulted with me, I would have advised them to talk with their son, listen to his views, try to understand the importance of contact for him with his birth mother, and ask for permission to communicate with

her themselves. By getting to know his birth mother, James' parents would be able to make more informed decisions and offer more informed guidance and support for their son.

Conclusion

Adopted children and their families present clinically with a myriad of symptoms and complex family dynamics. This pattern reflects the emerging diversity of adoptive family life today. No one clinical approach can be expected to serve the needs of all adoptive families. To be effective in working with adoptive families, mental health professionals must be adoption-clinically competent; they must bring an "adoption perspective" to their assessment and treatment of clients, recognizing the many adversities faced by these children and offering a range of interventions that address their clinical needs.

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