

Developmental Challenges for Adoptees Across the Life Cycle

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Adoptees face challenges becoming part of a new family in the context of separation from the biological family. To see adoption as a simple variation on the typical manner in which families are formed is to miss the complexity surrounding the processes of relinquishment and adoption.

As Brodzinsky, Smith, and Brodzinsky (1998) point out, overall adoption statistics are difficult to come by as national data have not been systematically collected for some time. States are not required to record or report the number of private, domestic adoptions, although international adoption statistics are reported. The Evan B. Donaldson Adoption Institute (1997) estimates that there are 1.5 million adopted children in the United States—that is, more than 2% of American children. When other members of the “adoption triad” (birth and adoptive parents) are added to these numbers, as well as extended birth and adoptive families and all those who will become connected to adoptees during their lives (e.g., adoptees’ spouses, children, grandchildren), the percentage of persons touched by adoption grows considerably. The Evan B. Donaldson Adoption Institute’s 1997 Public Opinion Benchmark Survey found that 58% of Americans know an adoptee, have adopted a child, or have relinquished a child for adoption.

Of children who are adopted in the United States, slightly more than half are adopted by birth-family members, often referred to as “kinship adoptions,” while the remainder are adopted by persons to whom they are not biologically related (Brodzinsky et al., 1998). Kinship adoptive parents have often become so reluctantly as a result of their own personal losses such as the death or inability of the child’s birth parents (e.g., their own child or sibling) to raise the child. The circumstances preceding relinquishment are often tragic and sometimes include the trauma(s) of neglect, abuse, or other mistreatment. In nonkinship adoptions, parents often adopt due to infertility, which carries its own issues of shame, sadness, and loss. The process of attempting to conceive a child and failing, often repeatedly, can be a lengthy and traumatic one for couples who ultimately choose adoption to create their families. These circumstances can put considerable strain on the couple as well as on each individual parent. In most cases, then, although it may not be the case for single, gay, or lesbian persons, adoption situations are not the first-choice route to parenthood. As Russell (1996) has noted, “People do not

expect to grow up, get married, and adopt a child” (p. 35). The adopted child therefore arrives into what is sometimes a setting of mourning as well as celebration.

Furthermore, adoptees themselves are often burdened by a lack of background information. As Russell (1996) pointed out, adoptees are the only Americans prohibited by law from seeing their original birth certificates. Instead, modified birth certificates are often created, with the adoptive parents listed as the birth parents, forcing adoptees to live “as if” they are part of a biologically unrelated family (Lifton, 1979, p. 14). While this has changed in some states, it is still the national norm. Accordingly, lacking historical information, an adoptee’s history begins with himself or herself. He or she loses not only the birth parents but also all the information about the birth parents, birth kin, racial identity, medical history, and other basic existential information which nonadoptees take for granted. All this secrecy and deception contributes to what has been described as a sense of “genealogical bewilderment” in the adoptee (Sants, 1964).

PRENATAL AND PERINATAL ADOPTEE EXPERIENCE

Maternal Stress and the Physiology of the Prenatal Environment

As Ingersoll (1997) pointed out,

Most adopted children . . . are born to young, unmarried mothers, a group who often do not receive adequate prenatal care. . . . Teenage pregnancies are also associated with low birth weight, which in turn is associated with behavioral and emotional problems in childhood. (p. 63)

Furthermore, mothers who experience an unplanned pregnancy often undergo great psychological stress. Emotional factors such as heightened, sustained anxiety are known to have many physiological effects. Just as unhealthy lifestyle factors, such as smoking and poor nutrition, are known to be risk factors for developing fetuses, psychological stress may also negatively affect the developing fetus.

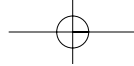
Thus, the mother who is young, stressed, and without optimal prenatal care, as is often the case with birth mothers who relinquish a child, carries her child in a suboptimal in utero environment.

From Prenatal to Perinatal

While often seen as a “win-win-win” situation for all members of the adoption triad, relinquishment and adoption also entail losses for all parties. As Verrier (1993) pointed out, even in the most ideal circumstance, the adoptee feels the loss of the birth mother, the birth parents feel the loss of their child, and the adoptive parents feel the loss of their fertility and genetic continuity. This foundation of loss, as described by Kirk (1964), contributes to the unique psychodynamics of adoptees, which Jones (1997) suggested includes “issues of loss, separation, abandonment, trust, betrayal, rejection, worth and identity” (p. 64).

The lack of appreciation of the gravity of loss for a neonate adoptee underestimates the significance of the in utero experience. During gestation, a developing fetus hears its mother’s voice, experiences her biological rhythms, and indeed shares her very existence in a most literal way. Verny and Kelly (1981) described the experience thus:

(The pre-natal bonding experience is) . . . at least as complex, graded and subtle as the bonding that occurs after birth. . . . His (the neonate’s) ability to respond to his mother’s hugs, stroking, looks and other cues is based on his long acquaintance with her prior to birth. Sensing his mother’s body and eye language is not very challenging to a creature who has honed his cue-reading skills in utero on the far more difficult task of learning to respond to her mind. (pp. 75–76)



Brodzinsky et al. (1998) also emphasized the inevitability of adoptee loss, regardless of age at placement:

For later placed children, the loss of family . . . connections is overt, often acute, and sometimes traumatic. In contrast, for children placed as infants, loss is of necessity more covert, emerging slowly as the youngster begins to understand the magnitude of what has happened. (p. 98)

So, even for an adoptee relinquished straight into the arms of the adoptive parents, the bond that has developed in utero with the birth mother is abruptly severed. The sudden loss of that familiar voice, smell, pattern of movement, and so on does not go unnoticed. Rather, the adoptee is aware of the disruption in the continuum of care. Even the most sensitive and skilled new caretaker will not be the person to whom the neonate has become accustomed in utero. Verrier (1993) characterized this separation as a “primal wound”:

When this natural evolution (from conception to care) is interrupted by postnatal separation from the biological mother, the resultant experience of abandonment and loss is indelibly imprinted upon the unconscious minds of these children, causing that which I call the “primal wound.” (p. 1)

Russell (1996) adds a note of irony when applying this to questions regarding disclosure of adoptive status: “Adoptive parents may find it reassuring to realize that, on some level, adoptees already know they were adopted. They were there.”

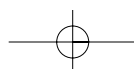
Even in infant adoption, then, adoptees enter a family in which the preplacement circumstances may have been less than optimal and with the trauma resulting from the abrupt severing of the only relationship they have ever known, the in utero relationship with the birth mother. Furthermore, an adoptive mother is at a disadvantage from the start as she has not had the benefit of the 40 weeks of in utero bonding to help her and her child become attuned to one another.

Adoptees subsequently face unique challenges in forming secure attachment relationships with their adoptive parents due to the resonance of this “primal wound” experience. If insecure in their parental attachment, some suggest they may later have additional difficulty intrapsychically separating from their parents in childhood, and later separating both intrapsychically and physically in adolescence and adulthood. Having once experienced parental loss, or abandonment, as it may be perceived, adoptees may be particularly fearful of and sensitive to the possibility of other losses, and this may hamper separation. Trust issues are both the cause and effect of these attachment challenges, for as Russell (1996) suggested, “If an infant is separated from the only mother it has known for nine months, it will be more difficult for that child to establish trust” (p. 66). Furthermore, the experience of growing up in an environment in which secrets are kept or deceptions perpetrated (i.e., when adoptees are denied historical information or given false information, such as modified birth certificates) can impede the development of trust.

ATTACHMENT DEFINED AND ITS FUNCTIONS

Attachment is a term used to refer to close, enduring, emotionally based interpersonal relationships. While attachment relationships exist between dyads of many kinds (e.g., spousal attachment, sibling attachment), the term in the present context refers to both the relationship between children and their parents or caregivers and the process by which these relationships develop.

John Bowlby (1977) saw attachment as an affectional tie with a preferred individual who is seen as stronger and wiser. He defined attachment behavior as “any form of behavior that results in a person attaining proximity to some other clearly identified individual who



is conceived as better able to cope with the world” (Bowlby, 1980, p. 203). Mary Ainsworth and her colleagues (Ainsworth, Blehar, Waters, & Wall, 1978) stressed the security aspect of attachment and coined the term *secure base* to describe what an infant should experience in a healthy attachment relationship.

Writing on attachment issues more recently, Melina (1998) echoed Ainsworth’s basic definition:

Attachment . . . is a reciprocal process between a parent and child. . . . It is the development of a mutual feeling that the other is irreplaceable. . . . Attachment . . . develops as the child learns that he can count on his parents to meet his physical and emotional needs. (p. 62)

Levy (2000) stressed reciprocity in parent/child attachment:

Attachment . . . is not something that parents do to their children; rather it is something that children and parents create together in an ongoing reciprocal relationship. . . . [I]t is a “mutual regulatory system” with the baby and caregiver influencing one another over time. (p. 6)

Bayless (1989) characterized this reciprocal relationship as a “cycle of need.” For example,

a cycle of need is initiated by the infant when they express hunger by fussing or crying. If the parent responds to the need by picking up the child while fixing the bottle, by holding the child while warming the bottle and by continuing to hold, stroke and talk to the baby during feeding, the cycle will continue as the baby responds by relaxing, smiling and cuddling. (p. 5)

Bayless asserts that after the cycle has been completed successfully several times, “the child will become positively attached to the person completing the cycle” (p. 5). Fahlberg (1991), who termed this the “arousal-relaxation cycle,” concluded, “Repeated successful completion of this cycle helps the child to develop trust, security and to become attached to his primary caregiver” (p. 34).

Case Study: Marta

Marta’s birth mother, Angela, was 15 when she became aware of her pregnancy. It was unplanned, and Angela was scared and nervous, and she kept it a secret as long as possible. She did not attend to her nutritional needs and did not receive standard prenatal care as a result. Marta was born at 34 weeks’ gestation well below normal birth weight and remained hospitalized for a short period during which she had very limited physical contact with Angela. Eventually she was deemed strong enough to be sent home to live with Angela and her parents, Marta’s grandparents. Angela was reluctant to handle the frail infant, and despite her best intentions, she lacked the emotional maturity and parenting skills to care for Marta in a reliable, consistent manner. She was not educated as to the need for consistent eye contact and reciprocal play. Marta’s schedule was erratic, and Angela either rushed to fill any possible need (she was not skilled at determining Marta’s needs accurately) when Marta fussed or did not step forward to relieve Marta’s distress if she was too tired or engaged in other activities. Angela’s parents were not comfortable with becoming grandparents so much sooner than they had hoped, both worked, and Angela attended school as often as possible, so Marta’s caretakers changed several times per day. As Marta progressed toward and passed her first birthday, other relatives began to observe that she was not hitting her developmental milestones (crawling, sitting up, babbling, standing, etc.) as they would have expected. She was wary of anyone she did not see regularly and seemed oblivious to opportunities for play with other children. She became increasingly difficult to comfort when frustrated and often looked to the side or over the heads of those who sought to interact with her.

ATTACHMENT'S LIFELONG REVERBERATIONS

For Bowlby (1977), the primary survival function of early attachment behavior is for the infant to secure the caregiver's nurturance and attention, so that the helpless infant will have its needs met. Furthermore, he proposed that "working models," or sets of internal representations about self and others, are formed as a by-product of the early attachment relationship with primary caregivers. These consist of sets of expectations and beliefs about whether caretakers are loving, responsive, and reliable, and whether the self is worthy of love, care, and attention. These determine to a large extent how an individual anticipates and construes self and others in interpersonal relationships. Bowlby (1979) warned that children whose basic needs have not been met consistently, and who therefore are not securely attached, might respond to the world either by shrinking away from it or by doing battle with it. Randolph (1994) similarly cautioned,

A failure on the part of the mother to provide consistent reciprocal interactions with her infant during the first year of life can have serious lifelong consequences. . . . He may develop attachment problems where he finds it hard to form close relationships with others, or where he is indiscriminately friendly with strangers. . . . Or he may develop the most severe form of attachment disruption, Attachment Disorder. (p. 5)

Attachment is not an all-or-nothing phenomenon. Theorists and researchers have developed categories to describe the quality and level of individuals' attachment "styles." For example, Ainsworth and Wittig (1969) categorized infants as securely attached, insecurely attached/avoidant, or insecurely attached/ambivalent, depending on their responses to the comings and goings of their mothers in an experimental situation. More recently, Main and Goldwyn (1985) developed the Adult Attachment Interview and categorized participants, in their recollections and descriptions of their early relationships with their parents, as secure-coherent, insecure-dismissing, or insecure-preoccupied. It is important to be mindful of Melina's (1998) words: "Attachment is a continuum, with securely attached children at one end, completely unattached children at the other, and the vast majority somewhere in between" (p. 79).

Where a child will fall on this continuum is greatly affected by the circumstances of relinquishment/placement and the consistency and reciprocity in the relationship with the permanent caregivers.

When relinquishment occurs at birth and a child is placed directly into a permanent adoptive home, the repercussions of prenatal physiological stressors, the "primal wound," and the disadvantage for the mother/child dyad in becoming attuned to one another's cues due to the lack of prenatal bonding all may still come into play and contribute to challenges in forming a secure attachment. In less ideal circumstances, such as when a child has been relinquished after experiencing poor or inconsistent care with the birth parent, and/or where the child has experienced multiple placements, the challenges are even greater. A child who has experienced unreliable, chaotic, neglectful, or inconsistent care cannot readily come to trust even the most well-intentioned, competent new caregiver.

Attachment is the early keystone on which other developmental tasks rest. A child who experiences consistent, reliable caretaking will feel secure and think that the world is a safe, benign place to explore. The child's tasks of gaining control of its body (grasping, walking, smiling), making appropriate eye contact, learning to regulate its emotions, developing language—all these can best be attempted in the context of a safe, reciprocal relationship with a primary caretaker. Similarly, these developmental tasks can be more difficult to achieve for a child who is not securely attached. These tasks are subject to delays if the primary task, attachment, is impeded in some way.

Some writers on the topic of adoption believe that, in the long term, adoptees' attachment outcomes do not differ substantially from those of nonadoptees. Fahlberg (1991), for example, believes that the development of attachment after birth proceeds in a nearly identical manner whether or not an infant is genetically connected to the parent, despite the severing

of prenatal bonds. Melina (1998) believes that birth parents may have an advantage, due in part to the innate in utero bonding discussed above, but that attachment in adoptive families generally is as strong as in birth families: "Intellectually, we know that natural childbirth, rooming-in and breast feeding are helpful but not necessary for attachment. Adoptive parents and their children . . . form attachments as successfully as do biological families" (p. 60). Bayless (1989) echoes this view: "The most important element in developing healthy attachment is neither blood ties nor the gender of the caretaker, but the nature of the relationship of this person to this child" (p. 3).

The limited amount of empirical research that has focused on adoptee attachment has yielded conflicting results. On the one hand, Brodzinsky et al. (1998) reported that the quality of mother/infant attachment in the middle-class families with same-race adopted infants he studied was comparable to that of mother/infant attachment in nonadoptive families. Furthermore, Juffer and Rosenboom (1997) found that internationally adopted infants displayed secure attachment relationships at rates comparable to nonadoptees. On the other hand, Horlacher (1989) found that adopted adolescents scored significantly lower on measures of reciprocity than nonadoptees, suggesting attachment impairment, and Fischman (1995) found that adopted adults were more insecurely attached, with increased feelings of abandonment and sensitivity to issues of object loss, than nonadoptees. However, Fischman also found that, when adoptees who had searched for birth parents were separated from those who had not searched, nonsearch adoptees did not differ from nonadoptees in terms of object relations and attachment. Thus, whether the views of Fahlberg (1991), Melina (1998), Bayless (1989), and others that adoptees do not ultimately differ from nonadoptees in terms of long-term attachment outcomes are supported by empirical research depends on which of the limited number of research studies one considers, and how one interprets their findings.

In all cases, an appreciation of the impact of the child's preadoptive experiences and an understanding of the need for attachment building (i.e., understanding that love alone is often not enough) will improve the chances of achieving healthy attachment outcomes for all children placed in adoptive homes.

Attachment Begets Trust, and Trust Is Necessary for Attachment

The word *trust* comes up frequently in the adoption literature, often in conjunction with discussion of attachment, as is evident from the foregoing discussion. Referencing the ramifications of the "primal wound," Verrier (1993) proposed that "the child's experience of abandonment causes him to mistrust the permanence of the present caretaker and to defend against further loss by distancing himself from her" (p. 66). Russell (1996) suggested, "If the infant is separated from the only mother it has known for nine months, it will be more difficult for the child to establish trust" (p. 66).

Trust is portrayed as an essential for the development of healthy attachments. Conversely, healthy attachment is seen as necessary for the development of a sense of trust. Thus, trust and attachment are often portrayed as opposite sides of the same coin: Trust allows for attachment, and attachment begets trust.

In addition to its generic meaning of confidence in the reliability and honesty of another, "trust" is also the positive component of the basic trust versus basic mistrust stage of Erikson's (1968) model of development. In each of Erikson's eight stages of psychosocial development, the individual wrestles with the polar opposite constructs which define the stage. In basic trust versus basic mistrust, the first of the psychosocial stages, which occurs from infancy to about 18 months, Erikson proposed that the mother's consistent meeting of the child's needs leads to the infant feeling a sense of continuity, security, and trust:

After emerging from the comfort of the uterus, the parents' ability to regularly meet (the child's) needs leads to trust and the expectancy of needs being met. . . . Mothers create a sense of trust in their children by that kind of administration which in its quality combines sensitive care of the baby's individual needs and a firm sense of personal trustworthiness. . . . [T]his forms the basis in the child for a sense of being "all right," of being oneself. (p. 249)

Brodzinsky and Schechter (1990) applied Erikson's basic trust versus basic mistrust directly to adoptees. They proposed that the most salient psychosocial task confronting an infant is the development of a basic sense of trust, and that in adoptive families, this is complicated by several factors, such as, of course, the separation from the birth mother. Verrier (1993) proposes that adoptees, due to the "primal wound" of mother loss, have difficulties in basic trust versus basic mistrust: "The loss of the mother disallows the achievement of basic trust, the first milestone in the healthy development of a human being" (p. 36). Verrier also proposes that these early trust issues may have long-term consequences: "The lack of trust is demonstrated over and over again in the adoptees' relationships throughout their lives" (p. 60). Weider (1977) too felt that early trust difficulties will have an impact on adoptees' future relationships: "Adoptees have difficulty trusting her [the adoptive mother] . . . or others who come to represent her" (p. 17).

Erikson (1968) himself characterized the development of trust as a crucial foundation for the child's first social achievement, separation from the mother, the intrapsychic process that Mahler, Pine, and Bergman (1975) termed *separation-individuation*.

STEPPING OUT IN THE WORLD

Separation-Individuation, Adoption, and Trust

Mahler et al. (1975) described the developmental process of separation-individuation that occurs from approximately birth to 36 months as the child's emergence from a symbiotic fusion with the mother (separation) and the assumption of his or her own individual characteristics (individuation).

Mahler et al.'s (1975) model describes a multiphase intrapsychic process:

The Separation-Individuation Process

- | | |
|------------------------------------|------------------|
| 1. Normal autistic phase | Birth to 4 weeks |
| 2. Symbiotic phase | 4 to 20 weeks |
| 3. Separation-Individuation Proper | |
| Differentiation subphase | 5 to 10 months |
| Practicing subphase | 10 to 16 months |
| Rapprochement subphase | 16 to 24 months |
| Object constancy subphase | 24 to 36 months |

During the normal autistic phase, the neonate is still half asleep. The major developmental task is to achieve homeostatic equilibrium. In the symbiotic phase, now more awake, the neonate functions "symbiotically" as if fused to the mother, not consciously perceiving or appreciating their separateness.

As noted earlier, however, trauma can result from the abrupt physical removal of neonates from the birth mothers who have carried them, and neonates are aware of this break. Applying this to adoptee separation-individuation, Verrier (1993) commented,

An uninterrupted continuum of being, within the matrix of the mother, is necessary for the infant to experience a rightness or wholeness of self from which to begin his separation or individuation process. The continuity and quality of this primal relationship is crucial, because it may set the tone for all subsequent relationships. (p. 29)

Even the adoptee relinquished at birth, then, carries the vestiges of this trauma into the normal autistic and symbiotic phases.

In differentiation, the first subphase of separation-individuation proper, the infant hatches from the autistic shell and engages in comparative scanning—that is, the infant begins to be aware of what is and what is not "mother." It is here, when the infant is first

aware that there is anything other than mother, that *stranger anxiety* can appear. Mahler et al. (1975) suggested that in children whose basic trust has been less than optimal, abrupt changes to acute stranger anxiety may occur. With this assertion, Mahler et al. directly related trust, the sine qua non of Erikson's model, to separation-individuation.

Logically, it is reasonable to assume that less than optimal attachment (or, the other side of the coin, less than optimal basic trust) will contribute to difficulties in separation-individuation. A healthy attachment provides the "secure base" Ainsworth et al. (1978) spoke of, away from which the toddler, physically and intrapsychically, separates. The more problematic the relationship with the foundation, or the weaker the trust in the base, the more difficult the process of moving away from it (i.e., separating) will be.

In the practicing subphase, at 10 to 16 months, toddlers gain a deeper understanding of separateness because of the achievement of locomotion. It is in this stage that *separation anxiety* appears. Given all the challenges outlined above, this anxiety may be more intense for adoptees than for other toddlers. So, for those with less than optimal attachment and lingering trust concerns, both stranger anxiety and separation anxiety may be more intense and stressful.

During rapprochement, toddlers are ambivalent in their desire for separateness. They may seek to reconcile the gap of which they are increasingly aware by engaging in clinging behavior, by running away from and then back to mother, and/or by bringing objects to their mother for the dyad to share together. For adoptees who are aware that they have already been separated from a primary object in a most literal and permanent way, this ambivalence in rapprochement may be heightened. Separateness may seem very dangerous.

In object constancy, toddlers internalize a coherent image of mother as, ideally, a reliable object. The experiences of the mother who comforts and provides for them is integrated with that of the mother who is sometimes absent or frustrates them as being one person, one good object. Adoptees may engage in aggravated "splitting," seeing an object as either all good or all bad, due to their dichotomous experience of dual parentage, and may therefore have greater difficulty than nonadoptees in achieving object constancy in their internalization of a coherent image of their parents.

Although the initial separation-individuation process was proposed by Mahler et al. (1975) to occur from birth to age 3 years, these authors also emphasized that new phases of the life cycle see derivatives of the earlier separation-individuation process. The degree to which an individual has successfully completed the separation-individuation process in the first 3 years of life will affect his later functioning. Verrier (1993) cautioned, "(for adoptees) separating seems to be an even greater problem than attaching. Once a relationship is established, many adoptees do not want to separate, even when the relationship proves unsatisfactory" (p. 90).

Adoptees in the Phallic and Latency Stages

It has been suggested that the adoptee may have more difficulty in resolving the Oedipus and Elektra complexes of the phallic stage of Sigmund Freud's (1909) psychosexual development model, since the parent-child relationship is not a biological one and, therefore, the "incest barrier" that helps to speed the resolution of these complexes does not apply in as clear a fashion in adoptive families.

Many writers have discussed the latency stage adoptee's unique experience of the "family romance" fantasy. This common reverie of the school-age child involves daydreaming about having different, perhaps royal or "superhero" lineage, and fantasizing that one has somehow been kidnapped or stolen by one's caretakers. They may fantasize about rescue and reunion with their rightful parents. As Sorosky, Baran, and Pannor (1978) stated, "The adopted child in fact has two sets of parents. He/she cannot use the 'family romance' as a game as the biological born child, because for him/her it is real" (p. 99). Furthermore, especially during times of stress in the adoptive family, adoptees may intrapsychically "split" their parents into the "all good" birth parents, about whom they fantasize in the family romance, and the "all bad" adoptive parents who are treating them so badly. So, dual parentage can present particular challenges in the achievement of Mahler's "object constancy," as well as complicate "family romance" reveries.

ADOLESCENCE AND THE ADOPTEE

Fahlberg (1991) described the adolescent separation-individuation process as follows:

The primary psychological tasks of adolescence echo the tasks of years one to five. The young person must once again psychologically separate, this time from the family, finding his place in society as a whole, rather than solely as a member of the family. (p. 107)

The adopted teen must separate from two sets of parents, one of which may be like ghost figures in his life. Separation may reactivate feelings of rejection, and independence may feel like abandonment. Again, separation may feel very dangerous.

A reworking of attachment issues is another task of adolescence. Kaplan (1984) described it thus: "The adolescent is like a mourner. . . . What the adolescent is losing, and what is so difficult to relinquish, are the passionate attachments to the parents" (p. 19).

Accordingly, when faced with the adoption-related challenges of letting go of attachments and separating into the larger society, as Sorosky et al. (1978) stated, "Adolescence is an especially difficult period for adoptees and their parents. . . . Adoptees appear to be particularly susceptible to the development of identity confusion" (pp. 105–110). Indeed, the penultimate adolescent question "Who am I?" is not so easily answered for persons intimately connected to two families, especially as they often lack birth-family information and may experience "genealogical bewilderment" (Sants, 1964) as a consequence. Brodzinsky, Schechter, and Henig (1992) proposed that "when adopted adolescents ask themselves 'Who am I?', they are really asking a two-part question. They must discover not only who they are, but who they are in relation to adoption" (p. 103).

Without a doubt, as identity formation goes hand in hand with the second separation-individuation and the shifting of attachments in adolescence, all these processes can be more complicated for adopted adolescents, as they are for adopted infants and toddlers.

Adoptive parents, too, can have difficulty with adolescent separation-individuation. As Pavao (1998) stated, "In many . . . families, not only do the kids have problems with loss and ending, but so do the parents" (p. 79). Adoptive parents sometimes fear that their teen, now old enough to do so without their help or approval, may search for birth parents and reenter their lives, perhaps even choosing the birth family over the adoptive family. These fears may be especially pronounced if there is significant conflict in the family, and thus adoptive parents may consciously or unconsciously thwart normal adolescent separation efforts because they, too, can fear abandonment, this time of the parent by the child.

Case Study: Thomas

Thomas was born to an impoverished Eastern European family and given the name Jacek. After struggling for several months to find the means to adequately provide for him, his birth parents relinquished him for adoption and he was placed in a relatively modern, well-run institution. He remained institutionalized and received passable institutional care while his waiting adoptive parents in the United States worked with their attorney and the government bureaucracy. When he was just under 1 year old, his adoptive parents flew to his birth country to bring him back to the United States. They renamed him Thomas. He had heard very little English spoken, and his adoptive parents did not speak or understand his native language.

Despite the challenges inherent in this scenario, Jacek/Thomas adjusted quickly to his new life. His adoptive parents were dedicated, well-versed in techniques to help speed the parent/child attachment, and very responsive to his needs. The trio became attuned to one another in short order. Though he exhibited several developmental delays, especially in the area of language development, Thomas soon caught up with his peers and developed age-appropriate skills.

As Thomas's parents prepared him for prekindergarten, he became more clingy and nervous and was easily unnerved by his parents' departures. He stammered occasionally and had occasional bed-wetting incidents. He was often hypervigilant and extremely driven to please, yet he occasionally threw tantrums which were followed by periods of sobbing.

GROWTH, LOSS, AND ADOLESCENCE

Loss is inherent in all development. As a new self emerges, the old self is given up, or lost. In adolescence, childhood is lost. Such inherent developmental losses, as described by Pavao (1998), are *maturational*, as opposed to *situational* losses, such as the objective and tangible losses of people in one's life. Normal maturational losses can be more difficult to work through for individuals with significant histories of situational losses. Adoptive families' histories are rife with situational losses, and their legacy can therefore complicate the maturational losses of adolescence, for the children and the parents. As Pavao (1998) stated,

For . . . adopted adolescents who have issues of loss and of disconnection, leaving home is extremely difficult. . . . Applying to college, moving away from home, beginning a family, carry with them strong and serious issues. (pp. 69–75)

As such, an adoptee's journey through adolescence, including a revival of separation-individuation issues, a shifting of attachments, and the struggle for identity, may be more stressful than a nonadoptee's, as all entail maturational loss, and loss is a core issue for adoptees.

ARE ADOPTEEES "AT RISK"?

It is reasonable to ask whether adoptees, given all of the above, as a group, experience more psychological difficulties than nonadoptees. Sorosky, Baran, and Pannor (1975) suggest that indeed adoptees are more vulnerable than the population at large because of the greater likelihood of encountering difficulties in the working through of the psychosexual, psychosocial, and psychohistorical aspects of personality development. Lifton (1994) described a set of traits and behaviors in the adoptees with whom she works, which she says result from "cumulative adoption trauma" (p. 7)—that is, the extra layer of losses and developmental challenges faced by adoptees. Kirschner (1990) suggested that the experience of loss and other facets of adoptive experience could create what he termed an "adopted child syndrome," characterized by personality and behavioral features such as impulsivity, low frustration tolerance, manipulateness, and a deceptive charm that covers over a shallowness of attachment (p. 93).

Adoptees' Overall Representation in Mental Health Settings

One way to assess whether adoptees are at elevated psychological risk is to consider the numbers of adoptees seeking mental health treatment relative to their prevalence in the general population. As Brodzinsky et al. (1998) stated, "Research has consistently shown that adopted children are over-represented in both outpatient and inpatient mental health settings" (p. 35). Indeed, statistics suggest that 5% to 15% of the American children brought for treatment in clinical settings are adoptees (Brinich, 1980; Brodzinsky et al., 1998). In one early study, Schechter (1960) reported that 13% of the children in his private practice were adopted. In summarizing his review of many studies of psychological risk in nonkinship adoptees, Brodzinsky et al. (1998) concluded, "The proportion of adopted children in outpatient clinical settings is between 3 and 13%, with a conservative mid-range estimate of 4 to 5%—at least twice what one would expect given their representation in the general population" (p. 35).

Methodological Problems in Research on "Adoptees"

One must interpret this apparent overrepresentation with caution. First, in some statistical analyses, all adoptees are grouped together regardless of prenatal experience, preadoptive experience, age at adoption, and other factors. This is problematic for many reasons.

As was noted earlier, children ultimately placed for adoption are often the products of stressed pregnancies. Furthermore, their birth mothers are often young women with limited access to quality prenatal care. Thus, inadequate prenatal care and a stressed in utero environment may result in children being born prematurely, with low birth weight, and so on. These factors sometimes contribute to temperament difficulties, the need for neonatal medical treatment, and other complications such as learning deficits. These may account for some of the apparent overrepresentation of adoptees in clinical settings, rather than adoption itself per se.

Additionally, regardless of prenatal experience, children who were placed for adoption subsequent to such traumas as abuse, neglect, and parental death are not merely “adoptees” but also children who were the victims of abuse, neglect, parental death, and so on. Therefore, it is misleading to include them in an “adoptee” group for the purposes of determining the percentages of adoptees in clinical populations just as it is misleading to include as “adoptees” children who were born prematurely, requiring intensive neonatal care, and so on, who happen to also ultimately be adopted. The roots of their mental health difficulties may have little if anything to do with adoption. It is often the circumstances preceding the relinquishment, or that influence a birth parent’s decision to relinquish, that account for the difficulties seen in some adoptees, not adoption itself.

In addition to these basic methodological problems, it has also been suggested that adoptive parents are quicker to seek care for their children than nonadoptive parents. Brodzinsky et al. (1998) suggest that this may be due to adoptive parents’ “greater vigilance regarding potential psychological problems in their children resulting from working with . . . mental health professionals during the pre-placement period” (p. 36). In a study of 88 adopted and nonadopted children presented for therapeutic treatment, Cohen, Coyne, and Duvall (1993) found that the families of the nonadopted children tended to experience greater dysfunction prior to referral than the adoptive families—that is, the adoptive families did not wait as long as the nonadoptive families to seek treatment. Consequently, clinical settings may see disproportionate numbers of adoptees. Furthermore, as McRoy, Grotevant, and Zurcher (1988) point out, compared with the general population, adoptive parents tend to be socioeconomically advantaged. In Ingersoll’s (1997) words, “Since adoptive parents are more affluent and better educated than parents in the general population, they are, therefore, in a better position to recognize psychiatric problems and to obtain appropriate treatment” (p. 59). Thus, one must be mindful that adoptive parents, as a group, may be hypervigilant and bring children for treatment more quickly, and they may be better equipped socioeconomically to readily secure mental health treatment, than nonadoptive parents.

Therefore, while it is reasonable that adoptees may be at somewhat greater psychological risk than nonadoptees, given the extra layer of developmental challenges they face, the statistics that suggest that adoptees experience psychological problems at minimally twice the rate of nonadoptees must be viewed with caution. As Ingersoll (1997) warns,

Parents and professionals alike should eschew the simplistic assumption that psychological problems in adopted children are primarily attributable to the fact of adoption, per se. . . . Parents and professionals alike . . . may overlook problems which exist independent of the fact of adoption. (p. 66)

Symptomatology in Adopted Children and Adolescents

As empirical research yields murky results regarding the degree of overrepresentation of adoptees in clinical settings, and methodological questions exist, one should also view empirical studies of symptomatology characteristically manifested by adoptees with a critical eye. For example, Silver (1989) found increased rates of academic problems and learning disabilities among adopted children. However, Wadsworth, DeFries, and Fulker (1993) found little or no evidence of increased rates of learning problems in infant-placed adoptees. Some research suggests that adoptees are more prone to display symptoms of Attention Deficit-Hyperactivity Disorder than nonadoptees (Dickson, Heffron, & Parker, 1990). Furthermore, some research found indications of increased rates of conduct

disorders in adopted children and adolescents (Kotsopoulos, Walker, Copping, Cote, & Stavrakai, 1993). However, Goldberg and Wolkind (1992) found significant differences in conduct problems only in adopted girls compared with nonadopted girls, with no differences between adopted and nonadopted boys. Still other studies found no differences whatsoever in conduct problems between adopted and nonadopted youth, male or female, in clinical settings (Dickson et al., 1990; Rogeness, Hoppe, Macedo, Fischer, & Harris, 1988). On the other hand, in his meta-analysis of adoption studies, Wierzbicki (1993) found not only that adoptees tend to display significantly more externalizing disorders than nonadoptees, but also that adopted adolescents tended to have a larger effect size than nonadopted children for both internalizing and externalizing disorders. In a longitudinal study, Fergusson, Lynskey, and Horwood (1995) studied 1,265 children in adoptive two-parent, biological two-parent, and biological single-parent homes. They found that the adoptee group experienced greater family stability and better mother-child interaction than children in the other types of homes. However, they also found that the adoptees exhibited conduct disorders, juvenile delinquency, and substance abuse at significantly higher rates than children raised in biological two-parent families but at lower rates than children raised in single-parent families.

So, while adopted children and adolescents are overrepresented to some degree in clinical populations, the empirical research literature does not consistently suggest that adoptees experience greater rates of specific psychological problems. Given the contradictory results of even just the few research results listed here, it is best to be mindful of the caution urged by Brodzinsky et al. (1998): "Whether adopted children are seen as at risk psychologically depends on the body of research that is examined" (p. 43).

FROM ADOLESCENCE TO YOUNG ADULTHOOD AND BEYOND

Given this extra layer of developmental challenges in attachment, separation-individuation, developing trust, resolution of psychosexual conflicts (oedipal issues, family romance confusion), identity formation, and other unique facets of adoptive experience, many have suggested that adoptees may be impaired in their ability to establish and maintain satisfying interpersonal relationships in adulthood. Russell (1996) opined, "It is typically the more intimate level of relationship that is difficult for adoptees" (p. 65). On adoptee identity formation and intimacy, Pavao (1998) suggests, "Intimacy? It takes knowing who you are to know who you can be with another" (p. 90).

Theory and research have consistently suggested a positive correlation between early attachment experiences and long-term outcomes for all individuals along a number of dimensions. Bowlby (1979) believed that "there is a strong causal relationship between an individual's experience with his parents and his later capacity to make affectional bonds" (p. 135).

Empirical data on attachment outcomes in adolescents and adults is mixed. Armsden and Greenberg (1987a, 1987b) found that adolescents' self-reports of secure attachment to parents positively correlated with self-esteem and negatively correlated with depression and anger. Homann (1997) found adolescent depression to be correlated with insecurity in maternal attachment. Sroufe (1983), reporting on his longitudinal research, asserted that children securely attached as infants were more resilient, independent, compliant, empathic, and socially competent in later life, with greater self-esteem than children who were insecurely attached as infants. Turkisher (1993) found that self-reports of secure attachment positively correlated with self-esteem and subjective well-being in young adults. Bradford and Lyddon (1993) found a significant negative correlation between self-reports of strong parental attachment and overall psychological distress in college students. Levy (2000), after an extensive review of attachment literature, summarized his findings:

Numerous longitudinal studies have demonstrated that securely attached infants and toddlers do better in later life regarding: self-esteem, independence and autonomy, enduring friendships, trust and intimacy, positive relationships with parents and other authority figures, impulse control, empathy and compassion, resilience in the face of adversity, school success, and future marital and family relations. (p. 7)

Investigating the literature on adult attachment outcomes and the quality of intimate romantic relationships specifically, Mikulincer, Florian, Cowan, and Cowan (2002) assert,

Attachment studies have consistently reported that persons differing in attachment style vary in a) the likelihood of being involved in long term couple relationships, and b) the vulnerability of these relationships to disruption. . . . More securely attached persons have been found among seriously committed dating relationships or married couples than in samples of single individuals. (p. 410)

Furthermore, “Secure persons, as compared with insecure persons, a) are more likely to be involved in long term couple relationships, b) have more stable couple relationships, and c) suffer fewer difficulties and/or disruptions in the relationship” (p. 411). Kirkpatrick and Hazan (1994) found that the relationships of secure persons were more likely to be intact after 4 years than were those of insecure persons.

These few examples from the research literature are typical in that they find early attachment experience as predictive of later satisfaction in intimate relationships. As discussed, research on long-term adoptee attachment outcomes is limited, and research on adoptee functioning and satisfaction in intimate adult relationships is more limited still. Logically, however, if we accept the premise that adoptees face more challenges in forming secure attachments in infancy, childhood, and adolescence, it follows that adoptees are more likely to face further challenges in forming and maintaining satisfying intimate relationships later in life. That this has not yet been sufficiently supported by empirical study does not negate the validity of the premise.

CONCLUSIONS

Adoptees are relinquished by birth mothers in whose bodies they have live for 40 weeks, and with whom they have formed a bond that cannot be replicated. They are placed, sometimes immediately, sometimes after an extra-uterine relationship with birth kin, sometimes after numerous foster placements, sometimes after suffering abuse or neglect, with adoptive parents who seek to raise them and create a family that is as like a birth family as possible. Regardless of the specifics, the child nonetheless experiences this separation from her birth mother as a trauma and often has little information about her heritage.

These experiences may complicate the individual’s developmental journey. In Erikson’s psychosocial model, the development of trust in the basic trust versus mistrust stage can be hampered due to the initial separation from the birth parent and other factors adoptees experience. Adoptees may have difficulty asserting themselves in later stages, due to fears of abandonment and feelings of indebtedness. Furthermore, adoptees may develop negative self-images as they compare their families with other families, and see some family systems as all good and others as all bad due to “splitting.” In adolescence, adoptees may have greater difficulty creating a solid identity and defining their roles. They may also have greater difficulty separating from their families than do nonadoptees. All these factors can culminate in adoptees having difficulties in creating satisfying, intimate interpersonal relationships in adulthood, and/or in severing unsatisfying relationships.

It is hoped that an increased understanding of the characteristics of adoptive experience will aid adoptees and adoptive families in overcoming the obstacles—some inevitable and

some self-inflicted—which relinquishment and adoption can place in the path of healthy individual and family development.

IMPLICATIONS FOR ADOPTIVE PARENTS AND BIRTH PARENTS

This chapter has focused on the needs and characteristics of adopted persons. Inherently, much of what is written here is relevant to adoptive parents, as a huge proportion of the materials presented here centers on the nature of the adoptee/adoptive parent relationship, and how this can help or hinder the adoptee in his or her journey to face challenges unique to those who have been relinquished by birth parents.

Adoptive parents will of course wish to avail themselves of the many publications, from books to magazines to newsletters, which are available to them. Furthermore, adoptive parents may wish to join with and learn from others by becoming involved with organizations such as the Adoptive Parents' Committee, with chapters throughout most of the United States. Adoptive parents may wish to participate in research activities such that academics and clinicians can better collect data that helps to further put the puzzle together, for the benefit of themselves and their children.

Adoptive parents should inform themselves as to how and why traditional parenting techniques may be ineffective, even counterproductive, when parenting the child who has a history of poor, chaotic, or inconsistent attachment relationships. Techniques based on the presumption that children trust and want to please their parents may not work with a child with a history of insecure or severed attachments. These parents need to avail themselves of all resources available to them. If times get tough with a youngster, these parents should be mindful of their own needs, including their need for rest/respice and their need for humor. Furthermore, asking for help is often the surest, least stressful way to overcome an obstacle.

For birth parents, this chapter may cause alarm. However, it should do the opposite. Birth parents should understand that, with the myriad resources and ever-growing body of knowledge out there, children they have relinquished have a better chance of successfully meeting their unique challenges than ever before. The odds that an adoptive family, armed with truth and knowledge about what is normative in adoptee development, what can be avoided and what is inevitable, what is realistic and what is naive/misguided, can help the child of any birth parent to thrive, should be of some comfort to a birth parent who worries. The delineation here of obstacles and challenges and pitfalls and possible negative outcomes that the relinquished child may face just demonstrates that many people out there are knowledgeable, concerned, and competent to understand and address their birth child's special needs.

REFLECTION QUESTIONS

1. How might knowing that those who raised me are not biologically related to me change my relationship with them? How might it change my image of myself? How might it affect my willingness to enter into close relationships with others?

2. Can I imagine that I was relinquished (or "given up") by those persons who feature prominently in my earliest childhood memories? How would my relationship with my current caregivers/parents differ if I had conscious memories of early experiences with other caregivers/parents?

3. From Pavao (1998): "What would it be like if you did not know another human being *on this earth* who was related to you?" (p. 65)

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