

---

# CLINICAL ENCOUNTERS WITH ADOPTION: THE IMPACT OF EARLY LOSS

## Angela Stupples

This paper presents the hypothesis that a form of attachment relationship between mother and infant begins before birth. That infants who are adopted are aware of the loss of biological mother in some way, and that this experience may influence the pattern of the attachment relationships formed within their adoptive families and with others. It is also suggested that the severance of this earliest attachment relationship is likely to resonate with other crises in later life bringing about a repetition or re-enactment of aspects of the original loss, and that this is especially likely to occur during the process of intensive psychotherapy.

### Introduction

New Zealanders were shocked three years ago by the sight of an ex-All Black and Member of Parliament, weeping uncontrollably in the House, during a debate which proposed that adoptees pay for the cost of gaining information about their birth parents. In a press interview later, Graham Thorne expressed surprise at his own emotional reaction, acknowledging that he himself was an adoptee who had recently made contact with his birth mother.

I too have been impressed by the emotional intensity around issues related to adoption as they arise during clinical work. I have begun to sense something about the emotional impact of being adopted on the infant as well as the mother, and it is the infant's experience, the manner of its being recalled, and its potential impact upon patterns of attachment, and later object relationships, which I discuss here.

The number of adult patients I have met in six years working at Ashburn Hall, who have had experience of the adoption process has surprised me. I have found myself wondering why this should be so. The conclusions I have reached are based upon concepts of attachment and contemporary theories of a dual memory system, as well as current thinking about the innate capacities of the newborn.

First some case vignettes, arranged so that they follow the natural sequence of the adoption process.

**One** I begin with the birth mother and her experience of her baby whilst pregnant and immediately following the birth, spontaneously describing the prenatal feeling of attachment to her child, which developed during the latter half of her pregnancy.

She is speaking of her baby whom she gave to his adoptive mother at age two

## **Clinical Encounters with Adoption**

---

days. “The time I had with him was so precious. I didn’t intend to get attached but it happened after the scan when I knew it was a boy. I was in town and a guy whom I didn’t like came up and put his hand on my belly, the baby kicked as if to say ‘take your hands off’, and I thought to myself, there he is, looking after his mother already.”

“After the birth I could hear him crying, I knew it was him even though he was in the nursery across the way, and on the second day I rang his mother and said, ‘come and get him, too many people are handling him and he doesn’t like it’.”

The baby’s grandmother adds the following: “We were watching him being dressed by his adoptive mother prior to leaving the hospital. He was crying and wouldn’t stop. Then T. [his birth mother’s boyfriend, who had been with her throughout the pregnancy and birth, and very involved] spoke to him, saying ‘hey little man calm down.’ He stopped crying immediately. I’m sure he recognised the voice.” The natural mother says, “he used to talk to him a lot before he was born.”

This account of parents sensing that their newborn has responded differentially to them is not unique. If you talk to friends and colleagues you will hear of many similar experiences.

**Two** The second example demonstrates the difficulties in forming a secure attachment relationship which are likely to arise for the adoptive mother and infant when the infant’s emotional attachment to the birth mother has begun to develop prior to the adoption.

Mrs Brown and Robert, aged six months, were referred by a sensitive adoption social worker because of concern about the lack of secure attachment between Robert and his mother.

He was the Brown family’s second adopted child. There had been no problems in their first experience with Lucy, aged three, whom Mrs Brown described as having clung to her from the moment she picked her up in the hospital where she had been left by her birth mother. In contrast, Mrs Brown felt that Robert did not care who looked after him and appeared to prefer to be with his father or grandmother.

The circumstances of Robert’s adoption were unusual. Mrs Brown met his mother before the birth and went to the hospital immediately after he was born with the intention of taking over his physical care. However this did not eventuate. Instead, over a period of seven days she watched the rapidly developing feeding relationship, and witnessed the intensity of his natural mother’s maternal feeling.

Robert was finally handed over at twelve days, after being at home with his birth mother for five days during which time he slept in her bed and was breastfed on

demand. He was inconsolable for the next two weeks and bottle-feeding was established with great difficulty. Mrs Brown struggled with feelings of extreme guilt about having taken him from his mother and was unable to bond, feeling that he was not her baby. The sight of him evoked memories of his mother and Mrs Brown felt that he did not smell like her child. Being a farmer's daughter and wife, she silently wished that something could be squirted up her nostrils to block the sensation as was done to ewes in the mothering up pens.

The first free play session clearly demonstrated the nature of their difficulties. Mrs Brown was unable to hold Robert for any length of time and placed him on the floor at a distance from her. He gazed around the room, and showed little interest in his mother, seeming to prefer the toys and the observing therapist. During the feedback time Mrs Brown recounted tearfully how angry she felt when he would not stop crying, and how she had eventually left three year old Lucy to comfort him.

Initially Mrs Brown found the non-directive aspect of the 'Watch, Wait and Wonder' technique difficult to carry out. It seemed as though she needed to be in control of the play and could not trust Robert's capacity to interact with her spontaneously. The baby had just learned to sit. His mother chose to play with him by using the toys, rolling a ball to him, and encouraging him to return it, showing him how to use the cars, always keeping him at a distance and separated from her by the toys. Somehow he managed to respond.

In subsequent sessions the physical distance between them gradually lessened and they became more mutually preoccupied. Robert learned to crawl and began to move towards his mother as well as away from her. At home he crept after her when she left the room and Mrs Brown slowly came to realise that she mattered to her son. Her feelings also began to change. She spoke proudly of taking him out shopping without her daughter, for the first time. Although Robert's play remained physically boisterous, he also began to have some quiet moments when he rested briefly against her, nuzzling the top of his head into her neck. He learned to stand up and loved using his mother as a climbing frame when she would allow, leaning against her shoulder and reaching for her hair.

Midway through the twelve planned 'Watch, Wait and Wonder' sessions, Mrs Brown had to leave Robert with a neighbour for some working days, in order to help her husband with the shearing. Robert responded to this separation with acute distress, refusing all food offered by the neighbour during the day and insisting on demand bottle feeding during the evening and night. After two days of worry about his not eating and the level of his distress, Mrs Brown solved the problem by having him in the wood shed with her, in a back pack, whilst she worked. Gradually, over several weeks he slowly got back on track with his feeding and sleeping routines. During sessions at this time he was quiet and subdued. In the feedback, Mrs Brown reported that Robert was now refusing to

## **Clinical Encounters with Adoption**

---

feed from anyone other than her, cried when left with his grandmother whom he had previously liked, and was restless at bedtime unless she put him to bed and spent some time stroking his head. Although Mrs Brown was proud of his need for her, and enjoyed the sense of exclusiveness in their relationship, she was also feeling drained and uncertain about this obvious change in the quality of his attachment, and the positive shift in their relationship was still fragile.

Robert and his mother attended fifteen 'Watch, Wait and Wonder' sessions in all. In the later sessions there was a steadily increasing display of physical closeness and pleasure in each other's playfulness. Robert learned to walk, and his delight in this achievement was reflected back by his mother's pride and enjoyment of him. They laughed together at times.

In the last family session the Browns reported that their social worker had offered to action the final adoption papers and Robert would soon be legally part of the family. Mrs Brown had been told by visiting friends that they saw her relationship with Robert as perfectly normal. She thanked me for helping her to 'click' rather than 'clash' with her baby. As she was leaving Mrs Brown was finally able to share that at the time of presentation, whenever her mother came to visit, she felt that Robert looked at her as though he was looking for his birth mother.

**Three** This example illustrates the experience of a re-enactment of the adoption experience during the process of individual therapy, when a pattern of insecure avoidant attachment to maternal figures is repeated in the therapeutic relationship.

Mary, who stated that she was adopted at birth in order to provide a daughter for her mother in an otherwise all male family, was hospitalised following her return to NZ shortly after her 21st birthday. She had been living overseas alone since leaving school at the age of 17. Upon admission, she was bulimic and obese, and was also withdrawing from long term addiction to amphetamines. She had no contact with her birth mother and knew little about her. Her adoptive family relationships were intensely ambivalent. She had two older brothers by whom she had felt tormented and excluded as a child, though she was closer to them as an adult. Her father, whom she had loved intensely, died of a heart attack in her presence when she was aged 14. When her brothers left home in the following years and she was left alone with her mother, she felt both stifled and lonely. She left school during the seventh form and after working for six months to save her fare, went overseas. As she put it: "I knew that I just had to get that far away from her". Their relationship had been mutually disappointing since early adolescence, at which time Mary had begun to perceive that she failed to meet the family expectations. In particular, the shift from a rural primary school to a city high school was a difficult adjustment. She was separated from friends and her work deteriorated. Her subsequent misbehaviour added to her alienation. With her chosen peers, she was socially very skilled and upon admission to hospital, she

quickly became a popular and powerful member of the ward group.

At the beginning of individual therapy sessions, words poured out in a continuous flow, leaving her distressed afterwards by the intensity of her feelings. However, this initial phase of therapy was followed by one in which there were long periods of silent withdrawal. Mary found it difficult to make use of the time, and something akin to self starvation seemed to be taking place.

The maternal transference relationship which developed was fragile and tenuous at best. Mary felt unable to trust my capacity to be empathic and at the same time non-intrusive. Her allegiance to me varied according to the fluctuations in her feelings towards her mother with whom she maintained frequent phone contact despite her ambivalence. When their relationship was positive, I was experienced as threatening and intrusive; when they were distant, as they often were due to mutual misunderstandings, I became the helpful therapist, insightful and empathic. Following a visit from her mother which both enjoyed, Mary withdrew further. She had been angry prior to the visit because I had spoken to her mother on the telephone without her permission, and this was used to widen the distance between us. Mary became silent and unreachable during sessions, eventually leaving me a note saying that she could no longer trust me and would not be continuing with her individual psychotherapy.

By this time we had been meeting three times a week for four and a half months and I was aware of being very attached to her. Upon my insistence she attended a further time but refused to discuss her decision, sitting with her face averted and refusing any eye contact. Whilst acknowledging my professional understanding of what was happening, I struggled to contain my own feelings as I interpreted her need to show me what it feels like to be given up. I wondered if the lack of eye contact between us was also an unconsciously recalled detail of her adoption experience. Was 'refusing to look' the only way her birth mother had been able to hand over her baby? I said that I sensed a little of the pain her mother had felt when she had to let go of her. Although tearful, Mary remained adamant about her decision. I refused to accept it, and continued to keep her appointment times despite her non-attendance.

At this time, she avoided any interaction with me, but worked well in other areas of the hospital programme, such as psychodrama and group therapy. However she consistently refused any suggestion from the nursing staff that it would be helpful to consider making contact with her birth mother, saying that she (Mary) would be a disappointment to her in her current state and situation.

With staff encouragement, Mary attended her last individual session. It was an emotional reunion. We were both tearful and relieved and able to acknowledge just how important we had become for each other. [I was bereaved as a child and also had daughters Mary's age who were in the process of leaving home]. Mary said "I got you hopelessly muddled up. You were yourself, my therapist, my birth

mother and my adoptive mother. I couldn't sort it out. I was determined not to become attached but I couldn't help it. I never thought I'd say it. I've been unable to look at you for months, the feelings are so enormous. I don't feel able to deal with them now, but I will do later, even if it takes me ten years. I know I've got to sort out my feelings about my mother, but I'm not ready yet. I'll go into analysis, maybe with Susie Orbach in London when I'm older."

**Four** Re-enactments can occur at times of crisis in later life.

Jan, a woman in her late forties, was referred for therapy because of conflict about the continuance of her marriage and her inability to make a final decision. In the first interview she offered, without prompting, that she had been adopted at birth, had a grown up family, and her marriage had been satisfactory without thought of separation for more than twenty years. By chance she had recently discovered that for several years her husband had been concealing from her the true state of their finances following the collapse of the New Zealand stock market. Although they were in no serious financial distress, she had since been unable completely to trust him, and had become increasingly angry and pre-occupied with thoughts of leaving him. As she spoke I found myself wondering how old she had been when she had been told that she was adopted. This had been made known to her at the age of nine, and she was only told then because her adoptive mother was dying. Her inevitable response had been to deny her anger and justify her parents' deception as appropriate to the times. However she could not make any such allowances for her husband. His deception was experienced as an unbearable blow which had killed her feelings for him and their marriage.

**Five** My last example comes from work with a young woman, adopted at birth, and her toddler son who was referred by their Plunket nurse because of behavioural difficulties. At eighteen months the little boy would not co-operate with his mother, but was easy to handle when cared for by his father, as was very evident in the assessment interview which he spent sitting silently on his father's knee.

During 'Watch, Wait and Wonder' sessions his mother told me that he was her second child, that she was very closely attached to her older son and devoted to her adoptive mother. After a normal hospital delivery the family decided that she would remain in hospital for the full ten days allowed so that her husband could complete the renovation of the kitchen before she brought the new baby home. The older child was being cared for during this first separation from mum by his maternal grandmother who had decided that it would be too distressing for him to visit his mother in hospital. The nett result of this was that the new mother had no visits from the three most important attachment figures in her life. She described her hospitalisation as being like an imprisonment, where she felt utterly alone with her infant. I do not know how long she remained in hospital

as a baby before being adopted or what the circumstances were, but I suggest that a primitive system of recall was triggered by this 'repetition'. It did not surprise me, therefore, that she had little capacity for empathy with her toddler, had left him with others from a very early age, and that both were angrily and ambivalently attached to each other.

### Clinical questions

What was re-enacted during the therapy of Mary and Robert and the experiences reported by the adopted adults? How did they all, as neonates, experience the inevitable loss involved in the process of adoption? In what ways may each have remembered or encoded their infantile experience?

Freud himself described the compulsion to repeat as a way of remembering [Standard Edition 1914] and although there is a crucial dividing line between pre-verbal and subsequent experience, psychoanalytic thinking has, as Kris put it [1956] "taken for granted that the impact of pre-verbal imprints may determine the modes of later reaction to environmental stimuli". Lenore Terr<sup>1</sup> states with conviction that young children who have no verbal memory of a traumatic event, are apt to re-enact it behaviourally; and Kerry Kelly Novick [1990] describes the process which occurs in therapy when pre-verbal memories are reactivated in the transference through the creation of tension states in the therapist. A review of current research into childhood events recalled by children and adults [Pillemer and White, 1989], is supportive of the probability of a primitive memory system operating from early infancy, alongside the later developing system of ordered storage and retrieval with which we are familiar. They suggest that this primitive 'remembering' is triggered by emotional resonance with current events, situations, feelings, and images.

But is it reasonable or otherwise to suggest that neonates are shocked or traumatised by the loss of biological mother at such an early age?

Much has been written about adoption from the adult perspective. A brief search of the literature produced scant reference to the impact on the baby. Indeed the point is made of the infant's plasticity to a variety of caretakers in the early weeks [Wolf, E. S. 1983] and the gradual development of attachment to specific others from around six weeks. Bowlby's<sup>7</sup> monumental work on the nature and significance of human attachment, published over a twenty year period in the 1960s and 1970s, fully acknowledges the significance of early separations and loss, but not in the neonatal period. Although the baby from birth behaves in ways which actively promote proximity and physical contact, the neonate's crying response is classified as a precursor of attachment phenomena rather than genuine attachment behaviour.<sup>8</sup>

However, this point of view becomes less convincing when consideration is

given to the findings of developmental research during the past ten years. These continue to reveal the innate discriminatory capacities of the newborn. Stern 1983<sup>3</sup> writes 'the infant is seen as an avid learner from birth, as highly competent in the sense of being pre-designed to perceive the world in a structured fashion and as mentally active in organising these pre-structured perceptions'. It is now common knowledge that full term newborns respond preferentially to the sound of their mother's voice and the smell of her breast milk within six days of life, and at seven days appear to have some visual recognition of her face [Lozoff et al.] as well as exhibiting significant self-regulating physiological changes when in her presence [Taylor, G. J. 1988]. Indeed, the practice of 'rooming in' in maternity hospitals is based upon the understanding that newborns establish regular feeding and sleeping patterns more readily if mother/infant separations are reduced to a minimum, in the first ten days of life. Conversely, Richards [1974] concluded that a separation immediately after birth, as was usual in the traditional hospital routine, affected both mother and infant, made breast feeding less likely, and was associated with less social contact throughout the first year. If we consider the sophisticated stage of development reached by the foetus in the last trimester of pregnancy, all this is not so surprising.

It is more difficult to know if an infant's physiological responsiveness to mother also indicates an emotional awareness or bond. Klaus and Kennell<sup>5</sup>, in the early 1970s, demonstrated that immediate post-partum contact between mother and child facilitates bonding and thus enhances maternal care and optimises development. However, their theory of a 'sensitive period' is understood to be critical for the mother rather than the infant, and has not been substantiated by later research. In other words they postulated that early separation affected the mother's feelings towards her baby and was not felt by the infant. Of particular interest to me is their description of the newborn's "unusual visual ability to attend and follow, especially in the period immediately after a normal birth". Again they indicate its significance for facilitating maternal rather than infant responsiveness, but Stern<sup>6</sup>, supplies what I think is important additional understanding when he describes this phenomenon as an example of the newborn's pre-structuring towards a rapid visual discrimination of the human face, although of course this does not imply any immediate, specific awareness or recognition.

In his concept of primary maternal pre-occupation, Winnicott [1956] recognised that the physiological process of pregnancy was accompanied, in mentally healthy women, by a developing state of psychological preparedness to engage with their infants after birth. I would like to suggest that like all beginning relationships, this is to some extent a two-way experience. Trevarthan's research into what he has called the newborn's capacity for inter-affectivity, adds support to this idea.



Roy Muir [1991] states it more simply, in his theory of transpersonal processes when he suggests that the transpersonal mode of relatedness is operative from birth and that there is strong evidence for some kind of vital semi-differentiated connectedness in the early weeks. In his words; “It is now apparent that infants do indeed enter the world with a great deal of pre-programmed readiness for certain kinds of organised experience, with preferences for certain kinds of stimuli; most particularly they are pre-programmed for relationship – for social interaction”. I would add, most especially with the already familiar maternal environment, which of course may also include father.

Any discussion of the neonate’s perceptual and cognitive capacities has a tendency to degenerate into a split between observable objective truth and an intuitively perceived subjective truth. It is an emotive area. I suggest that subjective experiences deserve consideration. It is my opinion that a specific biological attachment between mother and foetus inevitably develops, and it is this physiological loss of the familiar, with its psychological resonances, which is registered in some way by the infants who are adopted. I also suggest that this loss may be internalised or remembered in some primitive way, and is apt to be repeated in behavioural re-enactments in later life particularly when significant attachment relationships are threatened. It may happen in therapy, when the developing attachment to the therapist is experienced as threatening to existing relationships.

Much of this is intuitively known to us, but not always recognised. Nancy Newton-Verrier’s work is now well known and adoptive parents are beginning to feel confident enough to share some of the anxieties they have felt over the years about their adopted children. Mrs Brown felt enormously relieved when I suggested that Robert suffered a loss at twelve days, and that he brought his own difficulties into the beginning of their relationship. Failure to appreciate the significance of Mary’s compulsion to give up her therapy may have lead to an abrupt termination without insight or the experience of reunion.

To conclude, it seems reasonable to assume that disturbances in attachment will be common amongst children who are adopted, even at birth. If we can accept the fact that the infant sustains a significant loss, then it is more likely that difficulties will be recognised as they arise and intervention offered at an early stage. We cannot help an infant to grieve, but we can and should intervene to reduce the ongoing impact of the loss and encourage security of attachment relationships within the adoptive family.

We can begin as a professional group to give more consideration to the baby, who is after all, the central and most vulnerable figure in the adoption triangle. In this country we are only just beginning to develop some empathy for the potential of the infant’s experience. Any legislation should reflect first and foremost the infant’s need to know with certainty the family they belong to and the house

which is home. Adopted children have to grapple throughout the years of childhood with a concept which is only fully understandable in adulthood. We have a duty to make as simple as possible their task of comprehension.

Adoption presents a significant cognitive and emotional challenge to all those involved. Parents and children deserve all the clinical understanding and treatment support we can provide in order to make good the basic deficit. Current clinical experience suggests that at this point in time, in New Zealand at least, they do not always get it.

The last word, from a young woman adopted at six weeks. "I hate shifting, I always lose something precious which spoils all the happy memories. It's always been like that".

## REFERENCES

1. **Terr, Lenore C.** (1991). Childhood traumas: an outline and overview. *American Journal of Psychiatry* 148, p 13.
  2. **Wolf, Ernest S.** (1980). On the developmental line of self object relations. In Goldberg A. (ed) *Advances in self psychology*. New York, IUP, p 123.
  3. **Stern, Daniel N.** (1983). The early development of schemas of self, other, and self with other. In Lichtenburg S and Kaplan S. (eds) *Reflections of selfpsychology*. Analytic Press, p 58.
  4. **Taylor, Graeme J.** (1988). *Psychosomatic medicine and contemporary psychoanalysis*. IPU p 132. (Stress and Health Series Monograph 3)
  5. **Klaus, M H and Kennell, J H.** (1976). *Maternal-infant bonding*. St. Louis, Mosby.
  6. **Stern, Daniel N.** (1983). The early development of schemas of self, other, and self with other. In Lichtenburg S. and Kaplan S. (eds) *Reflections of selfpsychology*. Analytic Press, p 58.
  7. **Bowlby, J.** (1980). Loss, Sadness and Depression. In *Attachment and loss*. v 3, New York, Basic Books.  
(1969). Attachment. In *Attachment and loss*. v 1, New York, Basic Books.  
(1974). Separation. In *Attachment and loss*. v 2, New York, Basic Books.
  8. **Whyte, R.** (1991). Giving and taking: the foetal-maternal placental junction as a prototype and precursor of object relations. *British Journal of Psychotherapy* v 7, p 221 – 229.
  9. **Shawyer, J.** (1979). *Death by adoption*. Cicada, p 33.
- Also **Pillemer, D B and White, S H.** (1989). Childhood events recalled by children and adults. In *Advances in child development and behaviour* v 21.