Module #4. Clinical Issues in Providing Therapeutic Services: Grief, Loss, and Separation
Teaching Script

Acknowledgments: The Center for Adoption Support and Education wishes to thank Dr. Harold Grotevant and Dr. David Brodzinsky for their contributions of expertise in the development of this training module.
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Overview of Module:
In this session, students will examine the critical clinical issues of loss, grief and separation in adoption. Students will have opportunities to learn about the issues of grief and separation from the perspective of the adopted person, adoptive families and birth families. The session uses a grief model to develop/strengthen clinicians’ skills in working with adopted children, youth, and adults; birth parents in relation to voluntary relinquishment and involuntarily termination of parental rights; and adoptive parents. Evidence-informed clinical interventions that address these clinical issues will be identified and practiced.

Learning Objectives:
Students will be able to:

#1. Describe three ways that loss, grief, and separation impact adopted children, birth parents, and adoptive families and kin and give examples of each.

#2. Describe four ways that children express grief.

#3. List the four psychological tasks of the Good Grief Model.

#4. Describe two ways that a therapist can provide a safe, supportive and confidential environment for adopted children and youth.

#5. Demonstrate two clinical interventions in working with adopted children and youth to help them process their grief and loss.

#6. Identify three types of losses that adoptive parents may experience after the adoption.

#7. Describe two clinical interventions in working with a birth parent to process the experience of relinquishment/termination of parental rights and adoption.

Materials Needed:

- 2 flip charts and markers
- Laptop, LCD Projector, & screen
- Agenda
- Power Point Slides
- Video: *Unlocking the Heart of Adoption* (provided by C.A.S.E.)
- Two pages of blank paper for each student for individual writing exercise
- For Loss Box Activity: A variety of art supplies. Provide the supplies for students to do loss boxes or do one and bring it into class.
- A baby doll for the therapeutic ritual for birth parents
- Handouts:

  Handout #4.1 Kubler Ross Stages of Grief

© 2013 The Center for Adoption Support and Education
| Handout #4.2 | Adoption Glossary: Grief and Loss |
| Handout #4.3 | Case Examples: Adopted Children’s Experience of Loss |
| Handout #4.4 | The Good Grief Program of Boston Medical Center: What Children Need |
| Handout #4.5 | Alicia |
| Handout #4.6 | CASE Scripted Group Schedule: Group Therapy with Teens |
| Handout #4.7 | Amy |
| Handout #4.8 | Adoptive Parent Losses: Case Examples |
| Handout #4.9 | Obtaining Information from Birth Parents on Physical and Psychological Contact with their Children and Disenfranchised Grief |
| Handout #4.10 | PACT: Stages of the Grief Process for Birth Parents and Extended Family Members |
| Handout #4.11 | Ohio Child Welfare Training Program: Birth Parent Grief and Loss When Parental Rights are Involuntarily Terminated |
| Handout #4.12 | My Birth Father’s Legitimate Grief |
| Handout #4.13 | Elizabeth |
| Handout #4.14 | Emily |
Module #4. Clinical Issues in Providing Therapeutic Services: Grief, Loss, Separation and Identity

Pre-Module Assignments

Checklist:

✓ Pre-Module Assignment #4.1: Personal exercise regarding own experiences with adoption and loss.
✓ Pre-Module Assignment #4.2: Personal exercise regarding revisiting loss.
✓ Pre-Module Assignment #4.3: Test yourself on adoption, grief and loss and bring your answers to class.
✓ Pre-Module Assignment #4.4: Read Handout # 4.4 regarding the Good Grief Model.
✓ Pre-Module Assignment #4.5: Read Handout # 4.7 Amy, answer questions and provide answers to your teacher.

Pre-Module Assignment #4.1: As part of your clinical training, you no doubt have already explored connections between your own developmental history and your understanding of human behavior. It is important to identify aspects of your history that may relate to adoption issues -- most importantly, loss, grief and separation. Please reflect on issues in your own past that may interact with your understanding of adoption, using these questions:

• Do you have any personal connection with adoption (self, family, close friends)?
• What loss experiences have you experienced and how you have dealt with them?

Just for your own use, write down several key reflections as you think about each of these questions. There will be a chance to share any of your reflections in class if you choose to do so.

Pre-Module Assignment #4.2: Think about the losses you have experienced in your life that you have revisited in your life once or more. This could include loss of people, relationships, places, jobs, aspects of one’s self, imagined futures, pets, and so on. Write them down piece of paper. For each of these losses, ask yourself:

• What caused you to revisit any of these losses -- to reconsider them after you thought they had been dealt with?
• To what extent did others around you understand and validate your experience of loss? How would you feel if others minimized or invalidated what you had gone through?

There will be a chance to share your thoughts in class if you choose to do so.

Pre-Module Assignment #4.3: Complete the following quiz and submit your answers to the teacher before class. Bring your answers to class as we will discuss the right answers.

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How much do you know about how adopted children experience and express grief?

1. **True or False**: Adopted children bring multiple issues of loss with them into their adopted families, no matter what age they were adopted.

2. **True or False**: Childhood grief is based on many of the same issues that impact adults.

3. **True or False**: It is relatively easy to identify children’s grief reactions.

4. The Bonnet family adopted 8 year old Stevie from foster care where he had lived with three different foster families before being adopted. When he arrived, he had a normal appetite but after a week or so, he stopped eating when the family sat down together for dinner. He now barely eats breakfast or lunch and refuses to eat anything at the dinner table. Mrs. B recently discovered that he was hoarding food, hiding it under his bed. Are these behaviors possible signs of grief?
   - A. Yes
   - B. No
   - C. It depends on the type of food that Stevie ate at his last foster home.

5. Brad and Tim adopted three-year-old Amy who lived with her birth parents all of her life. Her birth parents placed her for adoption when they divorced and neither parent believed that they could raise her. Amy was toilet trained when she joined Brad and Tim’s family but now refuses to use the toilet, frequently soiling herself. When Brad gets ready to leave the house, she clings to his leg crying loudly until Tim pulls her off. Are Amy’s behaviors possible signs of grief?
   - A. Yes
   - B. No
   - C. It depends on the couple’s toilet training experience.

6. Marlene adopted 15-year-old Troy from foster care. Troy was in foster care for 10 years and few efforts were made to find an adoptive family for him. Marlene met him at his group home when she did volunteer tutoring there. After the adoption, the initial few weeks went very smoothly, but now, Troy alternates between deep sadness and anger. Are these possible indicators of grieving?
   - A. Yes
   - B. No, they are normative adolescent behaviors.

7. **True or False**: Children may cover their grief by being “perfect.”

8. Which of the following can a therapist use to help parents help their grieving children?
   - A. Help parents feel comfortable taking the initiative in talking with their child about loss and grief.
B. Help parents learn how to teach their children emotion words and expressions
C. Help parents recognize that even if they acknowledge and assist their children in the early years with grief and loss, their children’s grief will not be over.
D. All of the above

**Pre-Module Assignment #4.4:** Read Handout #4.4 which describes the Good Grief Model developed by the Boston Medical Center. We will talk about this model in class.

**Pre-Module Assignment #4.5:** One of the therapeutic approaches in working with older children and adolescents is the written role play. It is a strategy for facilitating the adoptee’s exploration of hopes, fears, beliefs, and expectations in relation to birth relatives. As such, it can play a therapeutic role in helping a child or young person deal with feelings of loss and grief, as well as identity.

What is involved: The older child or adolescent client chooses a birth family member to write to. (It is not intended that the letter will ever be sent.) The therapist asks the client to write whatever he or she wants to that person – it can be done in the session or outside. Next, the therapist asks the client to assume the role of the birth family member who has received the letter, and asks the client to respond in writing as that person. Next, the therapist asks the client to respond in writing to the response of the birth family member, and so on. This process is called “correspondence with the self.”

Please review Handout #4.7 Amy that provides an example of the use of a written role play, answer the following questions, and provide your answers to your teacher prior to class.

**Questions:**

1. When Amy returns to therapy at age 15 because she is interested in her biological origins and wants to make contact with her birth relatives, her therapist encourages to do a written role play. How would you as Amy’s therapist describe the written role play exercise to her?

2. As Amy’s therapist, what would you take into account in encouraging her to do this? What skills and/or attributes might you want a young client to have before suggesting this work?

3. How would you work with Amy around the first set of written role play letters? What in particular would you focus on?

4. How would you work with Amy around her letter to her birth mother after she reads her birth mother’s letter to you?
Pre-Module Assignments Checklist for Teachers

Students’ Pre-Module Assignments -- Due to You Prior to Class:

Pre-Module Assignment #4.5. Students are to write answers to the following questions about the work with Amy (Handout #4.7) and submit them to you.

1. When Amy returns to therapy at age 15 because she is interested in her biological origins and wants to make contact with her birth relatives, her therapist encourages to do a written role play. How would you as Amy’s therapist describe the written role play exercise to her?

2. As Amy’s therapist, what would you take into account in encouraging her to do this? What skills and/or attributes might you want a young client to have before suggesting this work?

3. How would you work with Amy around the first set of written role play letters? What in particular would you focus on?

4. How would you work with Amy around her letter to her birth mother after she reads her birth mother’s letter to you?

Teachers’ Assignments Re: Pre-Module Assignments: Summarize the students’ responses to the question about Amy in Pre-Module Assignment #4.7 and prepare a handout for distribution in class.
Module #4: Clinical Issues in Providing Therapeutic Services: Grief, Loss, Separation and Identity

Agenda

9:00AM – 9:15 AM Welcome; Announcements
9:15 AM – 9:30 AM Introduction
9:30 AM – 9:45AM Bringing Adoption Into the Clinical Assessment
9:45AM – 10:30AM Our Own Experiences of Loss, Grief and Separation
10:30AM – 10:45AM Break
10:45AM – Noon Movie: Unlocking the Heart of Adoption
12:00PM – 1:00PM Lunch
1:00PM – 1:20PM Debrief: Unlocking the Heart of Adoption
1:20PM – 3:00PM The Impact of Grief and Loss on Adopted Children and Youth
3:00PM -- 3:15PM Break
3:15PM – 4:15PM Grief and Loss: Adoptive Parents and Birth Parents
4:15 PM – 4:30PM Summary and Closing

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Welcome to this session that will discuss the clinical issues of grief, loss and separation in adoption.

Large Group Discussion: Before we begin, what issues related to adoption arose for you since we last met?

Today, we will look at three key clinical issues in adoption: loss, grief and separation. We will consider issues of grief and separation from the perspectives of the adopted person, adoptive families and birth families. We will use a grief model to develop/strengthen our skills in working with adopted children, youth, and adults; birth parents in relation to voluntary relinquishment and involuntarily termination of parental rights; and adoptive parents. We will also look at some evidence-informed clinical interventions that address these clinical issues.

Here are our learning objectives.

Students will be able to:

#1. Describe three ways that loss, grief, and separation impact adopted children, birth parents, and adoptive families and kin and give examples of each.

#2. Describe four ways that children express grief.

#3. List the four psychological tasks of the Good Grief Model.

#4. Describe two ways that a therapist can provide a safe, supportive and confidential environment for adopted children and youth.
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#5. Demonstrate two clinical interventions in working with adopted children and youth to help them process their grief and loss.

#6. Identify three types of losses that adoptive parents may experience after the adoption.

#7. Describe two clinical interventions in working with a birth parent to process the experience of relinquishment/termination of parental rights and adoption.

9:30AM – 9:45AM  Bringing Adoption into the Clinical Assessment [All Objectives]

In order to address the clinical issues of grief, loss, and separation with adopted persons, prospective adoptive parents, birth parents and extended birth family and adoptive families, we must fully incorporate information about adoption into the clinical assessment.

Large Group Discussion

How comfortable are you in raising the subject of adoption with the individuals and families with whom you are working? Can you give an example of a case where you asked about adoption early in the counseling process and were glad you did? Can you give an example of a case where you did not ask about adoption early in the counseling process and later wished that you had done so?

Some clinicians honestly admit that they have difficulty asking parents whether they adopted their child and the reasons surrounding their decision to build their family through adoption.

Large Group Discussion:

Why might clinicians have difficulty asking about adoption?

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As part of the clinical assessment, it is essential that as clinicians, we feel comfortable asking parents whether their child is adopted. How might we pose this question to parents?

Note to Trainer: Use the following to prime the discussion if needed: “Please tell me how your family came to be formed”; “why did you choose adoption as a way to build your family?” or “what led to your decision to adopt?”

9:45AM – 10:30AM    Our Own Experiences of Loss, Grief and Separation [All Objectives]

In order to be able to work effectively with individuals and families who lives have been touched by adoption around issues of grief, loss and separation, we need to be aware of the impact of grief, loss and separation on our own lives.

In your pre-session work, you completed two assignments related to your own experiences of loss, grief and separation. In the first assignment, we asked you to reflect on any personal connection you have with adoption and then to think about your own experiences of loss and how you have dealt with these losses in your life.

Large Group Discussion: Would anyone like to share their reflections on these issues?

In the second assignment, you were asked to think about those losses and what, if anything, has caused you to revisit any of these losses – that is, to reconsider them after you thought they had been dealt with. We asked you about how others around you understood and validated your experience of loss or, alternatively, minimized or invalidated what you had gone through.

Large Group Discussion: Would anyone like to share their reflections on these issues?

10:30AM – 10:45AM    Break

10:45AM – Noon    Movie: Unlocking the Heart of Adoption [All Objectives]
Most of us have explored the issues of loss, grief and separation in our graduate work and in our professional practice. Today, we want to look specifically at these issues for individuals and families who have been touched by adoption, building on the understanding you already have of these issues and also discussing the concept of ambiguous loss – with which you may already be familiar. Let’s begin with a useful perspective from Reitz and Watson, *The Adoptive Family System*:

“Families linked in adoption come in as great variety as the range of human possibilities permit. Regardless of their particular link to adoption, they must deal with the universal human needs for attachment, generativity, and coping with loss. The only certain commonality among these families is that they have undergone fundamental loss experiences beyond those that any family can normally expect. No other common experiences can be assumed for all families linked in adoption“ (p. 13).

Loss is recognized as a **if not THE** key issue in understanding clinical issues in adoption. In some cultures, the issue of loss does not seem to be very central. Especially in some non-industrialized communal societies, adults share parenting responsibilities as needed, and children do not belong solely with biological relatives. Informal “adoption” is common; families don’t think of it as adoption – they are working as a community to raise the children. As a result, there is not the sense that a child is subtracted from one family and added to another. However, western culture, with its emphasis on biological connection as a defining feature of family, accentuates the profile of loss as a part of the adoption experience.

Let’s watch the powerful video, *Unlocking the Heart of Adoption* by Sheila Ganz. This documentary bridges the gap between birth and adoptive families through diverse personal stories of adoptees, birthparents and adoptive parents in same race and transracial adoptions interwoven with the filmmaker’s story as a birthmother. It reveals the enormous complexities in these individuals’ lives with fascinating historical background. We will watch the video then break for lunch. When we return from lunch, we will have a chance to talk about the video and the perspectives of the individuals on grief, loss and separation.

**Noon – 1:00PM**       **Lunch**

**1:00PM – 1:20PM**       **Unlocking the Heart of Adoption: A Debrief [All Objectives]**
Large Group Discussion

- What is your immediate impression of the concerns that the individuals featured on the video expressed about the adoption experience – specifically about loss? How did these stories expand or change your knowledge of adoption?
- As a clinician, do these stories help you to understand adoption-related loss better?

You may wish to learn more about the people featured on the documentary. More about their stories can be found at: http://unlockingtheheart.com/www/index.htm

1:20PM – 3:00PM  The Impact of Grief, Loss, and Separation on Adopted Children and Youth
[Learning Objectives #1, #2, #3, #4, #5]

Lecture

Loss is an inherent part of adoption. In adoption, people who are adopted lose their birth families, birth parents lose their children, and adoptive parents lose their dream of the child they originally wanted to have. The structure of adoption is such that to create an adoptive family a birth family must be separated. In many situations, there are added layers of loss in adoption: the loss of health, siblings, cultural familiarity and caregivers. The losses of the adopted child may be passed on to the adoptive parents and birth parents via tentative and precarious relationships.

Our response to loss is called grieving, which involves a complicated array of emotions and behavior. Grief is a normal response to loss; it’s not considered pathological. Unless loss is recognized, however, grieving cannot take place. On the other hand, grief can become so persistent that it interferes with daily living. Grieving can lead to depression and perhaps other clinical problems. As a result, a thoughtful evaluation of the client’s response to loss is important.

Recognizing the stages of grief can help adopted children and youth, adoptive parents and birth parents understand that they are experiencing appropriate feelings. Adults, children, and even infants can show the signs and symptoms of loss and grief. When the losses of adoption are addressed, the gains of adoption can be more fully appreciated.
We are all familiar with the Kubler-Ross Stages of Grief. Look at Handout #4.1 which describes these stages of grief.

Handout #4.1 Kubler-Ross Stages of Grief

Here is an example of how grief and loss may impact a school age child who is in foster care and for whom adoption will become the plan:

Shock/Denial – 'My mom will be here soon to pick me up.' The child refuses to participate in any discussions about what will happen, saying that her mom will come and bring her home.

Anger – 'I hate Social Workers. They don’t understand anything about me or my family' or 'Police officers lied about my dad. He wouldn’t do any of the things they said he did.' The child may cry uncontrollably or become angry when simple requests are made, such as getting ready for bed or being told no.

Bargaining – The child may begin to realize that she will be in foster care for some time. The child may silently pray or believe the following: 'If I’m allowed to go home I’ll be the best kid. I will help keep the house clean. I will get the top grades in school.'

Despair/Depression – The child realizes that her mom is not coming for her. She thinks, 'Who is going to take care of me? Did I make this happen? I give up. Why me? I’m so alone.'

Acceptance/Understanding/Resolution – The child understands that she cannot go home and that the adults around her will help her be in a loving family. She may think, 'I’m here with this family, and I’m safe. This is not my fault. I did not make this happen. Adults make choices for me. I need to do my best to share my feelings with adults around me that I trust. I will get through this and be OK.'

Small Group Work: At each of your tables, discuss how these stages of grief may impact an adolescent in foster care for whom adoption is the permanency plan.
Report Out: Let’s hear from each group about how these stages of grief may impact an adolescent.

Lecture: Loss and Grieving in Adoption

Grieving in adoption is different in some distinct ways from mourning the death of someone who has died. When someone dies, there is a definite ending that allows grieving to begin. In adoption, there is no death, no ending. In adoption, a state of limbo exists that is similar to the dynamics of mourning someone who is missing in action. It is difficult to mourn someone who is alive but unavailable. These realities bring into play the concept of ambiguous loss.

Large Group Discussion: No doubt, some of you have encountered the concept of ambiguous loss in reading or in your own practice. What does ambiguous loss mean?

[Note to Trainer: Acknowledge participants’ understanding and application of ambiguous loss in their practice. Make the following points as needed.]

Loss in adoption is distinctive because ambiguity is involved. Given that most adoptees recognize that various members of their birth family probably are alive, the loss related to adoption may not involve clear closure, such as with death. It is useful to consider Pauline Boss’ concept of ambiguous loss, when there is a disconnect between psychological and physical presence. As an example, ambiguous loss may occur in a closed adoption – the child’s birth relatives may be psychologically present (in their thoughts and feelings), yet physically absent and unknown. Even in an open adoption with periodic contact, birth relatives are likely to be physically absent on a day-to-day basis. The same may be true for birth parents: the child may continue to be psychologically present to them despite many years of physical absence.

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Large Group Discussion: Why is ambiguous loss so devastating?

[Note to Trainer: Make note on the flip chart of the reasons provided by the group. Make the following points if not mentioned:]

Of all losses experienced in personal relationships, ambiguous loss is most devastating because it is:

- Unclear/confusing
- Indeterminate
- Most distressful
- Immobilizing – cannot problem solve because a person does not know if the loss is final or temporary
- Lacks resolution

Large Group Discussion: Ambiguous loss may be particularly profound for children who are adopted. What might we see clinically when adopted children lack certainty in their lives?

[Note to Trainer: Make the following points if not mentioned:]

When children lack certainty in life, they may exhibit difficulty in:

- Relating to others
- Developing a clear and integrated sense of self
- Developing self-confidence
- Feeling they belong
- Developing self-motivation
What we know is that ambiguity may:

- Erode children’s sense of mastery
- Cause children to feel incompetent
- Create feelings of helplessness
- Create feelings that the world is unfair, unsafe, unpredictable, and unmanageable

Clients often find that the ambiguous loss framework helps them understand their experiences by naming and describing them.

Handout #4.2 provides a glossary of adoption loss and grief terms and may be a good resource for you.

Lecture

It is not uncommon to hear adoption and mental health professionals talk about "resolving" issues of loss.

Large Group Discussion

- What do you think it means to “resolve a loss”?
- Does “resolution” mean that one never thinks about the loss anymore? That it is completely understood and dealt with forever?

Note to Trainer: Raise the following points if not mentioned:
• “Resolution” does not mean that loss is completely understood and dealt with forever.
• The key to remember is that “resolving” loss means integrating it into one’s sense of self in a way that does not interfere with daily living. But even people who have accomplished this integration sometimes revisit the loss.

Lecture: The Impact of Grief and Loss on Adopted Children and Youth

In Being Adopted, David Brodzinsky talks about grief and loss for adopted children and youth by using a metaphor of keeping losses in a box. Sometimes you are able to keep the box closed and go on with your daily routines, although not forgetting what is in the box. However, circumstances in life sometimes occur that make you return to the box, open it up, and explore it once again. Then after some reconsideration, you put it back in the box for a period of time. The issue is still there, but not always foremost on your mind.

Let’s examine the possible losses for adopted children and youth and how we can work with them. Look at Handout #4.3: Case Examples: Adopted Children’s Experience of Loss. Come back into your work with others at your table. I will assign one case to each table. Please talk about the potential losses that your assessment might focus on in the assigned case and discuss the potential impact of these losses on the adopted child/young person.
Note to Trainer: Ask a student from each table to read the assigned case and share the key losses that the table identified and at least one potential impact as a result of these losses. Possible answers are listed below:

Case #1  Sam and Terry, a white couple from Minnesota, adopted Amanda from China when she was age 18 months old. She had been left by the side of the road and was found by a family who took her to an orphanage. Amanda is now 10 years old.

Losses:

- Loss of birth parents
- Loss of extended birth family
- Possible loss of birth siblings
- Loss of non-biological caregivers from the orphanage
- Status loss (related to stigma associated with adoption)
- Loss of county of origin
- Loss of privacy (the fact of adoption will be evident)
- Loss of “fitting in” when child looks very different from family
- Loss of native language

Case #2  Sonita adopted Cassandra, a thirteen year old, from the foster care system. Sonita is Latino; Cassandra is African American and Native American. Cassandra has an older brother who aged out of foster care two years ago. She does not know where he is.

Losses:

- Loss of birth parents
- Loss of extended birth family
- Loss of sibling
- Loss of foster parents and possibly foster siblings
- Loss of other meaningful relationships while in foster care (e.g., friends, teachers, etc)
- Status loss
- Potential loss of cultural/racial heritage
- Loss of privacy
- Loss of fitting in

Case #3  Betty adopted Brian as an infant. He is now 8 years old. Betty lives in Connecticut; Brian’s birth mother lives in Montana. Betty knows that Brian has two older sisters by birth who have a different father than Brian. Brian’s birth mother told Betty that she just didn’t think that
she could handle a boy on her own. Brian’s birth father had minimal contact with Brian before
the adoption and has not contacted Betty since she adopted Brian.

Losses

- Loss of birth parents
- Loss of extended birth family
- Loss of half siblings
- Status loss

Case #4  Lori and Tammy adopted 8 year old Shonisha from foster care. They live in California;
Shonisha was in foster care in Florida where she had lived with the same for three years and
had attended the same school since kindergarten. When she was in Florida, her maternal
grandmother visited her often.

Losses:

- Loss of birth parents
- Loss of former caregivers
- Loss of extended family members
- Loss of school/friends
- Status loss

Case #5  Beth adopted Tanika at age 14 from foster care. She is now 16 years old. Tanika has
two younger sisters (Dominique and Tami) who were adopted by a different family before
Tanika was adopted. When they were with their birth parents, Tanika was the one who took
care of the younger girls. When they entered foster care, she was separated from them and
then they were adopted. She continues to have some contact with them but she feels that the
relationship has changed.

Losses:

- Loss of birth parents
- Loss of siblings
- Loss of status within the birth family
- Potential sense of loss of self
Lecture

In her book, *Adoption and Loss*, Evelyn Burns Robinson states that adopted children “...suffer from the loss of their relationship with their natural mothers, the loss of kinship as they are separated from their extended family and community, and the loss of identity from not knowing exactly who they are” (italics added) [Robinson, 2000].

Large Group Discussion: Notice Evelyn Robinson’s use of the term “natural mother.” What would you say about the use of this term in light of our earlier discussions about positive adoption language?

Note to Trainer: Raise the following if not mentioned:

- It is easy to fall into adoption language that undermines the relationships of other key people in a child’s life – for example, calling the birth mother the “natural” mother implies that the adoptive mother is an “unnatural” mother.

- Referring to “mothers” leaves out the child’s connection with his/her birth father, possibly siblings, and other members of the extended family.

Large Group Discussion: What about the specific types of losses that Evelyn Robinson describes: loss of kinship and loss of identity? Have you seen these losses in adopted children and youth with whom you have worked?
Lecture

In addition to losing a relationship with their birth mothers and fathers, adopted children may lose other relationships, objects of importance to them, and other connections.

Large Group Discussion: What are specific losses may adopted children and youth experience as a result of adoption?

Note to Trainer: Add the following to the discussion if not mentioned: Loss of:

- Birth siblings or half-siblings
- Extended birth family (grandparents, aunts / uncles / cousins, etc.)
- Former caregivers and supports (e.g., foster parents, teachers, therapists, etc.)
- Status (within the family or within the school)
- “Fitting in” with the adoptive family – e.g., by looking different from everyone else
- Stability in their lives (if history of multiple foster placements)
- Genealogical continuity – for identity as well as medical / genetic history purposes
- Racial/ethnic/cultural origins
- Privacy (to the extent that the adoption is publicly visible)
- Self/identity

Lecture

Adopted and foster children, no matter what their age, embark upon their new lives facing loss. They have lost their caregivers, their clothes and bedding, familiar smells, tastes, and sounds, the way they do things, their ability to feel comfortable with their lives and in some cases, their language, and their daily
routines. Theresa Anderson, a family counselor specializing in issues of adoption, attachment, and grief says, "Grief is THE core issue that adopted children deal with...grief and terror."

Adoptive parents often come to clinicians out of concern for their children’s adjustment. They often need help in understanding how to identify their children’s grief, assist them through their grief issues, and help them grow from that grief. Adoptive parents may struggle to create opportunities for their newly adopted children to grieve their losses and their past. They may need assistance in acknowledging that throughout their children’s lives, their children may need assistance with grief.

In your pre-session work, you completed a self-assessment on our knowledge about how adopted children experience and express grief. Let’s discuss the answers!

*Note to Trainer: Ask students how they responded to each question and the make points that follow after each question as needed:*

1. **True or False**: Adopted children bring multiple issues of loss with them into their adopted families, no matter what age they were adopted.

   Adopted children **DO** bring multiple issues of loss with them into their adopted families, no matter what age they were adopted. If a family adopts a baby, they may mistakenly assume that the child’s life begins with them. If they adopt an older child, they may wrongly assume that their past is now their past. In reality, adopted children bring multiple issues of loss with them into their adopted families, no matter what age they were adopted.

2. **True or False**: Childhood grief is based on many of the same issues that impact adults.

   Childhood grief is **NOT** based on many of the same issues that impact adults. Childhood grief is often based on different issues than those that impact adults. Donna O’Toole, grief counselor and author of Helping Children Grieve and Grow, writes, "Especially for children a loss may be based on safety, comfort, and familiarity, rather than on what adults speak of as love or affection."

3. **True or False**: It is relatively easy to identify children’s grief reactions.

   It is **NOT** relatively easy to identify children’s grief reactions. Children usually do not tell their adoptive parents that they grieving. It is important to look at what children are doing and saying.

   What might children’s loss and grief look like? The following are possible ways that a child might express grief and loss – but it is important to recognize that these can be
related to issues other than grief. No single issue is determinative of grieving. Children are highly variable in the way they grieve.

- Developmentally stuck
- Increased magical thinking
- Assume the role of victim
- Hyper/lack of intimacy with others
- Expectation that others will leave
- Undefined guilt
- Chronic worrier
- Mask feelings with compulsive behaviors
- Difficulty feeling calm/nurtured
- Less open to love
- Anxious/depressed
-Disconnected from others
- Cannot form new attachments

4. The Bonnet family adopted 8 year old Stevie from foster care where he had lived with three different foster families before being adopted. When he arrived, he had a normal appetite but after a week or so, he stopped eating when the family sat down together for dinner. He now barely eats breakfast or lunch and refuses to eat anything at the dinner table. Mrs. B recently discovered that he was hoarding food, hiding it under his bed. Are these behaviors possible signs of grief?
   a. Yes
   b. No
   c. It depends on the type of food that Stevie ate at his last foster home.

   YES, these behaviors are possible signs of grief. Changes in appetite and hoarding food are possible reactions of grieving children. These behaviors may be indicative of other issues as well.

5. Brad and Tim adopted three-year-old Amy who lived with her birth parents all of her life. Her birth parents placed her for adoption when they divorced and neither parent believed that they could raise her. Amy was toilet trained when she joined Brad and Tim’s family but now refuses to use the toilet, frequently soiling herself. When Brad gets ready to leave the house, she clings to his leg crying loudly until Tim pulls her off. Are Amy’s behaviors possible signs of grief?
   a. Yes
   b. No
   c. It depends on the couple’s toilet training experience.

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YES, Amy’s behaviors are possible signs of grief. Regressive behaviors and clinginess may be possible grief reactions for children. These behaviors may also indicate trauma.

6. Marlene adopted 15 year old Troy from foster care. Troy was in foster care for 10 years and few efforts were made to find an adoptive family for him. Marlene met him at his group home when she did volunteer tutoring there. After the adoption, the initial few weeks went very smoothly, but now, Troy alternates between deep sadness and anger. YES, these are possible indicators of grieving. Possible reactions of grieving children include anger and sadness. Anger and sadness may also indicate other issues for the child. Are these possible indicators of grieving?
   a. Yes
   b. No, they are normative adolescent behaviors.

   Yes, these behaviors are possible indicators of grieving.

7. True or False: Children may cover their grief by being “perfect.”

   True. Children may cover their grief by being “perfect.” Children may cover grief – as well as trauma -- with being perfect or by controlling others.

8. Which of the following can a therapist use to help parents help their grieving children?
   a. Help parents feel comfortable taking the initiative in talking with their child about loss and grief.
   b. Help parents learn how to teach their children emotion words and expressions
   c. Help parents recognize that even if they acknowledge and assist their children in the early years with grief and loss, their children’s grief will not be over.
   d. All of the above

   A therapist can use ALL of the following to help parents help their grieving children.

The issues of loss, grief, and trauma that adopted children face upon adoption do not disappear once they have adjusted to their new lives. Adoption-related grief issues are re-visited throughout their lives. Ed Entmacher, a North Carolina psychiatrist who works with children and families says, "Grieving over adoption issues doesn’t happen easily or neatly. It has to be revisited over and over into adolescence and adulthood."

Large Group Discussion: So, how did you do on the quiz? Any questions or comments?
Lecture

How children react to loss varies across a continuum:

Fleeting awareness       -----       Intermittent       ------------       Feelings of fragmentation
                         of emotional  periods of  and emptiness & intense, enduring
                             pain          stress                 feelings of deprivation

Small Group Work: Identify at least 5 factors that may influence how a child reacts to loss.

Report Out

Note to Trainer: Raise the following if not mentioned:

- The child’s attachment to parent
- Age and developmental stage of the child
- Cognitive and developmental immaturity reduces internal coping abilities and distorts interpretation of placement experience
- Developmental immaturity which affects understanding and emotional reactions to stress
- Past experiences with separation
  - Number of moves decreases the child’s reaction to separation: “numbness”
  - Increased moves decreases ability to form close attachment
  - Lack ability to form “intimate” relationships
  - Develop fear of abandonment and self doubt
- How the child sees loss
  - Lack of control over situation
  - People outside of family have more power than parents
  - Someone gave me away: didn’t measure up (sadness, guilt, and depression)
o Taken away (anxiety and fear)
o Caused the separation
o Adults not trustworthy

• Temperament/personality of child
• The way loss occurs and is communicated to the child
• How successful we are in validating the child’s grief
  o Permit/invite children to express feelings
  o Share similar experiences of other children
  o Accept the child’s continuum of feelings

• Information: keep the child informed as to why separation occurred and what is happening now
• Availability of support and the child’s ability and willingness to utilize the support

Lecture: The Good Grief Model

We are using today the Good Grief Model developed by the Boston Medical Center. In your pre-session work, you read Handout # 4.4 which provides some of the core principles of this model.

Handout #4.4 The Good Grief Program of Boston Medical Center: What Children Need

Large Group Discussion: What are the four psychological tasks of grief work?

Note to Trainer: Write on a flip chart each task as students identify them and discuss each one as follows:
1. **Understanding**: knowing what happened to the person who left and why, or knowing what situations caused the loss and why it happened

2. **Grieving**: experiencing the painful feelings associated with a loss

3. **Commemorating**: remembering the persons, places, things that are no longer part of the child’s daily life

4. **Going on**: The child learns that the pain of grief subsides and the legacy of their loved one lies within themselves

**Interventions with Children and Youth**

We will be looking at different clinical approaches to accomplish these four psychological tasks of grief work with children. Here are some principles that guide our work:

- Unresolved separations will interfere with formation of new relationships
- New attachments are not to replace old ones
- We can free children from the past by providing a process to grieve past losses
- Children fear re-occurrence of pain of losses and avoid intimacy
- Adults who show support of child’s emotions as the child copes with grief support the development of new attachments
- Adoptive parents must accept that loyalty issues will exist but that children can love more than one person

We will focus on clinical work with adolescents because, as therapists, we are likely to see more adopted adolescents in our practice than younger children. In working with adolescents, we must afford them an opportunity to express their grief and mourn their losses. The treatment goal is to provide the adolescent with the opportunity to affirm, mourn, and manage these profound losses. There are several strategies that clinicians can use in working with older children and youth.

**Life Books**

We talked at length in our last session of the therapeutic benefits of life books for children and youth. Life books are probably one of the most frequently used clinical tools for working with children and youth about loss and grief.
The Loss Box

The Loss Box provides teens with an opportunity to identify and acknowledge their losses. The Loss Box has not been subjected to rigorous research but clinically, it is used by therapists and has gained acceptance as an effective approach to working with adopted children and youth around loss.

To begin the use of this tool, the therapist typically talks with the teen about the power of losses upon their lives and the impact that loss has when we do not get in touch with the uncomfortable feelings connected to loss. The therapist tells the teen that there is a helpful project that they can participate in to begin to carefully and slowly explore the important things that he/she has lost. The teen is given the opportunity to pick out a simple shoe box and decorate it in any way he/she would like. The Loss Box is the teen’s. An array of art materials is supplied and as the teen decorates the box, the therapist talks about the purpose of creating the box.

Once the box is decorated, the therapist carefully guides the teen in beginning to identity his/her losses. As the teen identifies each loss, the therapist encourages him/her to share his/her understanding of why the loss occurred. Each acknowledged loss is then recreated through artistic expression – drawing, collage, writing (poems, word, thoughts), or clay work (as examples). During this process, the therapist helps the teen explore what was significant about the person, place, things and gives permission for the teen to talk about what it feels like to have lost what was so important. The teen has the opportunity to grieve losses in a safe, nurturing, and supportive environment in a way that is developmentally appropriate. It is very important to allow the teen to process at an emotional pace that is safe for him/her.

Using the Loss Box is a slow process. It is not a tool to use in a one session. It is a technique to utilize periodically throughout the therapy with children/teens who are suffering from unresolved losses. We will now have the chance to work with a loss box – although for a very short period of time!

Loss Box Activity: Options

Option #1: Ask students to pair up and use the shoe box they were asked to bring to class and the art supplies being supplied. Ask the pairs to think about a young adopted person with whom one of them is working and then create a possible loss box with one of the pair role playing the young person and other role playing the social worker. Allow about 15 minutes for this activity. Follow up with a discussion of participants’ thoughts about the loss box as a way of helping young people identify and acknowledge their losses.
Option #2: Trainers construct a loss box and bring it into class. Introduce the loss box and describe the process trainers use to create it. Pass the box around and facilitate a discussion about the use of loss boxes to help young people identify and acknowledge their losses.

W.I.S.E. Up

It is during the middle childhood years that children encounter questions from school mates about adoption. These questions may trigger additional feelings of grief and loss.

What might be some questions from school mates that could trigger these feelings?

After discussion, review the following questions, highlighting those not mentioned:

Some of the questions that children may hear are:
- Who is your real mother? How come she didn’t keep you?
- Don’t you want to find your real mother?
- I hear you were left in an orphanage. What was wrong with you?
- Is your mother a prostitute?
- Do you have a dad? Where is he? How come he didn’t marry your mother?
- I hear that all kids in foster care were abused. What happened to you?
- How do you know what you will look like when you grow up?
- How can that be your mother? Her skin isn’t dark like yours.
- How much did your parents pay for you?
- Is your real mother a drug addict?

A tool that can be used to prepare children for adoption is W.I.S.E. Up! developed by the Center for Adoption Support and Education. W.I.S.E. Up the Owl leads young readers through the book with questions about feelings, different ways the topic of adoption is brought up by peers, and how to handle situations as they arise. Children are given choices on how to respond with several different examples. W.I.S.E. Up the Owl also introduces the topic of adoption in the media and asks children to examine what they have seen, heard, and read and to decide what they think about the way adoption is portrayed. Is it true information or not?

The letters in WISE stand for the four options children have for responding to questions and comments about adoption:

- W Walk away or ignore what is said or heard
- I It’s private and I don’t have to answer it

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CASE’s Teen Treatment Model

The Center for Adoption Support and Education uses a “Teen Treatment Model” that involves the teen in individual and group therapy, the family in family therapy, and parent support and education. We are focusing today on the clinical interventions with teens: individual therapy and group therapy.

Individual Therapy

In individual therapy with a teen who is adopted, the therapist:

- Provides a safe place for exploration of adoption issues
- Give permission to the teen to grieve losses
- Validates the teen’s sense of confusion as he/she moves to consolidate a sense of self
- Educates the teen to developmental issues in adoption

Alicia, a spirited 15-year-old, adopted from Guatemala when she was 6 years old. She recently took a drug overdose at school. After she physically recovered, she comes with her mother and father to see you. She quickly informs everyone that she has no intention of saying anything and the whole thing “is a big waste of time.” Her parents report that Alicia’s hostility has been growing. After she was expelled from public school for drug use, her parents enrolled her in a private school but it is uncertain whether the private school will allow her to remain. Alicia says that she couldn’t care less. You ask the parents to describe why Alicia is being referred for therapy and then ask them to wait in the waiting room.

Question #1. Now alone with Alicia, you face her anger. She immediately says, “I’m tired of coming to this kind of thing – you are just like the rest of them – I want to leave.” How would you respond to Alicia?
Question #2. When you acknowledge her anger and reflect on her need to self-medicate her pain, Alicia snaps, “Why do you give a shit what I do with my anger? It’s not your problem.” How would you respond?

Question #3. You acknowledge that she is correct and add, “But it certainly seems to be a problem for you – we wouldn’t be sitting here together if it weren’t. You know, I have seen lots of teenagers who are adopted and have very strong feelings about their adoption experience and sometimes difficult, painful things have happened to them.” Alicia just glares at you. How would you respond?

Question #4. Alicia blurts out, “You would be pissed too if you had to leave your little brother at the orphanage and never said good bye.” What tentative conclusions are you drawing at this point?

Question #5. After talking with Alicia, you invite her parents to rejoin you in the session. What would you want to share with the parents at this point?

Report Out

Ask groups to report back on how they responded at each step in the dialogue with Alicia and their tentative conclusions.

Lecture

To complete Alicia’s story, here is what the therapist learned about Alicia’s background. When Alicia was placed with her adoptive family from the orphanage at the age of 6, her younger sister already had been sent to another orphanage. Alicia did not share with her parents that she had a younger sister. She has been living in a state of denial, protecting herself from the painful truth of the loss of her sister.

Group Therapy
Group therapy has a distinct advantage for adopted teens: it provides a social milieu for growth and emotional healing; it provides opportunities to identify with other teens and normalize experiences (“I’m not alone!”); it helps teens release stigma and shame; and it validates for teens the universality of their issues.

Research evidence has grown about the effectiveness of group therapy for adolescents when the therapeutic relationships in the group have relationship structure and relationship quality. Structure refers to the direction of the relationship. In describing direction, vertical cohesion refers to a group member’s perception of the group leader’s competence, genuineness, and warmth. Horizontal cohesion describes a group member’s relationship with other group members and with the group as a whole. The quality of the group relationships is defined by how members feel with their leader and with other members (positive bond), by the tasks and goals of the group (positive work), and also the empathic failure with the leader and conflict in the group (negative relationship). The research on the evidence base for group therapy for adolescents is in your reading list.

Here is a quote from a teen in a group therapy program for adopted adolescents:

“I thought I was the only one who every thought about what it would have been like to have been raised by my birth parents.”

The Center for Adoption Support and Education uses a scripted group schedule for its group therapy work with teens. Handout #4.6 provides the scripted group schedule that CASE uses. Please review this on your own.

**Handout #4.6  C.A.S.E. Scripted Group Schedule: Group Therapy with Teens**

**Written Role Play**

In your pre-session work, you read about the therapeutic approach in working with older children and adolescents called written role play and you are now familiar with it. This practice is not described in the literature on evidence-based practice. It is a practice that is early stages of use.

You read Amy’s story that is in Handout #4.7 and you answered questions about how you might work with Amy in doing a written role play.
Handout #4.7   Amy

Note to Trainer: Provide a summary handout of the responses of the participants to the four assigned questions. Use their responses to open the discussion.

1. When Amy returns to therapy at age 15 because interested in her biological origins and wanted to make contact with her birth relatives, her therapist encourages her to do a written role play. How would you as Amy’s therapist describe the written role play exercise to her?

2. As Amy’s therapist, what would you take into account in encouraging her to do this? What skills and/or attributes might you want a young client to have before suggesting this work?

3. How would you work with Amy around the first set of written role play letters? What in particular would you focus on?

4. How would you work with Amy around her letter to her birth mother after she reads her birth mother’s letter to her?

Lecture

In working with children and young people, it is critical to clarify at the outset of therapy, both with the child and parents, how privacy/confidentiality of information shared by the child will be handled. Children may tell the therapist things he/she does not want shared with parents. The therapist needs to be clear about the ground rules for keeping things private or sharing them.

In his book, Parenting Adopted Adolescents, Gregory Keck says that when parents bring an adolescent to therapy, he discusses what information will not be confidential – such as physical or sexual abuse, dangerous use of alcohol or drugs, and safety issues. He says that there is usually an understanding that family matters are shared with the people who are involved in treatment. Dr. Keck says that in many cases, an adolescent will ask, before saying something, “will you tell my parents?” In response, he reports that he says, “It depends on what you tell me,” and then goes over what he would either need or want to share.
One of the most important ethical considerations is creating a zone of safety for clients. Some will be exploring feelings or situations they have held privately. Others will be exploring family secrets and how to deal with them. In group work, it is important that the group establish norms about keeping group discussions confidential.

The therapist should always be aware of situations that may be beyond his/her current level of expertise. In such cases, be sure to reach out for consultation or supervision with colleagues who have more experience in this area.

Let’s turn now to grief and loss issues that impact adoptive parents and birth parents.

Adoptive Parents

Lecture: Adoptive Parent Loss

As we discussed in our last session, adoptive parents also experience loss in adoption. We talked about the types of losses that prospective adoptive parents’ experience. Once they adopt, adoptive parents may re-experience losses that are triggered by the inherent loss of adoption. Their children’s loss and grieving may reactivate loss for them as well. The losses are parallel – the child’s loss and the adoptive parents’ loss. This was the theme of David Kirk’s (1964) seminal book, “Shared Fate,” which we have already discussed.

Large Group Discussion: What experiences have you had in working with adoptive parents around issues of loss and grief?
Note to Trainer: Assign one case to each table. Ask each table to discuss possible losses for the adoptive parent in the case and how they would assess the impact of these losses— the questions that would ask? Allow about 5 minutes for this activity.

CASE #1: Beth adopted a two-year-old girl from Russia. Her daughter, Allie, has had a difficult time adjusting to life in her new family. Allie refuses to be comforted and flinches when Beth tries to put her arms around her.

Types of loss: Loss of fantasized birth child who would be affectionate and cuddly

Questions to assess: How do you feel when Allie flinches when you try to comfort her?

When you adopted Allie, what did you imagine your relationship with her would be like? Is your relationship with her different from what you imagined? How does this feel?

CASE #2: At the same time that Katie adopted a two-year-old boy from Columbia, her sister Sissy gave birth to a little boy. At age twelve, Sissy’s child is a “chip off the old block” — smart and with a talent for softball, just like his grandfather. Katie’s son, Kenneth, hates sports and refuses to play. He is not doing well in school.
**Type of loss:** Loss of “fit” with child (when the child is quite different from parents in ways not expected); loss of pride/status given that her son is not meeting expectations like her sister’s child is doing

**Questions to assess:** When you adopted Kenneth, what did you imagine he would do as he reached this age? Did you imagine that you, your parents, and your sister would do certain things with him?

Do you find yourself comparing Kenneth to Sissy’s son? If you do, what do you think and how do you feel when you do these comparisons?

**CASE #3:** Mack and Mira adopted Evan from foster care at age 8. They were told that he had physical health problems, including asthma and a history of rheumatic fever, and whooping cough. Since adopting Evan 2 years ago, Evan has experienced chronic skin rashes, chronic earaches, ongoing dental problems, and repeated respiratory crises. Mack and Mira feel “worn down.” When they come in to talk with the therapist, they reveal that they experienced 4 miscarriages before they adopted Evan.

**Type of loss:** Grief over failed pregnancies; loss of the fantasized (i.e., healthy) child

**Questions to assess:** Tell me about how you came to adopt Evan. What was having the miscarriages like for you? What are the miscarriages like for you now?

When you adopted Evan, what did you imagine he would be like as a baby? As a toddler? How do his health problems fit into what you imagined?

**CASE #4:** Donna, a single adopted mom of 16-year-old Cami, underwent unsuccessful infertility treatment for two years before deciding to adopt Cami at age 8 from foster care. Cami is now openly expressing her sexuality and Donna is depressed and anxious almost all of the time.

**Type of loss:** Loss involved with failed fertility treatments; perhaps loss of fantasized child; perceived loss of sexuality/sensuality

**Questions to assess:** Tell me more about how you came to adopt Cami. What were the infertility treatments for two years like for you? How do you remember them now?

When you adopted Cami, did you have expectations of she would be like as a teenager? Now that she is a teenager and is experiencing sexual feelings and engaging in behaviors that have a sexual component, how do these feelings and behaviors relate to your own feelings about your infertility?
Assessments of the range of losses that adoptive parents may experience is essential to our quality work with them and their families.

**Large Group Discussion:** How might you build into your assessment work with adoptive parents issues of grief and loss? Can you give examples of your clinical work with adoptive parents around these issues?

**Birth Parents and Extended Birth Family Members**

We are going to look at three issues related to birth parent losses: the extent to which they have physical contact with their child; the psychological presence or absence of the child in their lives; and disenfranchised grief.

**Physical Contact**
Whether the client is a birth mother or birth father (or other birth relative), it is necessary to understand the history of their contact with their child and the child’s adoptive family. Handout #4.9 provides questions that can help the therapist in understanding the situation and in working clinically with birth parents. Let’s briefly review the first part of this handout together.

**Handout #4.9  Obtaining Information from Birth Parents On Physical and Psychological Contact with their Child and Disenfranchised Grief**

**Large Group Discussion:** Review the question on Handout #4.9 about birth parents’ physical contact with his/her child. These questions are applicable both to birth parents whose children were removed by the courts and birth parents of children who they voluntarily relinquished. Which of these questions seem most important to you? Would you add questions to this list?

- What were the circumstances of your making an adoption plan? Or, if you did not make an adoption plan, how was the plan made?
- Have you had any contact with your child or child’s adoptive family since placement?
- If so, when? how frequently? with whom?
- Is the contact continuing? If not, why?
- How have the most recent visits gone? Please tell me about your last visit.
- If there is no ongoing contact, are you able to re-establish it if you want?
- Is there an agreement now with the adoptive family regarding contact? verbal or written?
- What would your ideal contact situation be, for right now?
- What are the factors standing in the way of this ideal situation?
- Does your child or the child’s adoptive family have a different idea about contact than you do?
- Is anyone else from your family involved in the contact? (your partner, other children, parents, other birth relatives, etc.)
- How does that go?
Psychological Presence/Absence

One of the biggest challenges in working with birth parents is helping them cope with the ambiguity of their loss. As we already discussed when we talked about ambiguous loss, stress can occur when a family experiences a disconnect between psychological and physical presence of a loved one. For birth parents, it is most likely that the child will be physically absent (all or part of the time) while psychologically present.

Handout #4.9 contains questions that can be asked of birth parents about the psychological presence or absence of their children:

- How often do you think about the child you placed for adoption?
- Do you have dreams or daydreams?
- If so, what are they like? (explore emotional qualities attached to dreams or daydreams: happy memories, frightening, sad, etc.)
- Are there certain times of the year when you experience this loss more keenly? If so, when, and what do you do? (Many birth parents report such thoughts on the child’s birthday, major holidays such as Christmas, and Mother’s Day.)
Look at the two questions for discussion on Handout #4.9. Discuss and prepare to report out:

1. How would you work with a birth parent who tells you that she thinks about her child every day and often has happy daydreams about seeing him again, only to then feel extremely sad? Her parental rights were involuntarily terminated by the court. Her child, age 10, was adopted by a family in another state and she has had no physical contact with him.

2. How would you work with a birth father who, while incarcerated, voluntarily relinquished his rights to his 14 year old son after the mother’s rights were involuntarily terminated. He was released from prison 6 months ago. He describes intense sadness on his son’s birthday and periodic dreams in which his son is crying as he is led off to prison. He does not have physical contact with his child, though the agency has not closed the door on contact if the adoptive parents agree.

Report Out

Lecture: Disenfranchised Grief

It is useful to talk with birth parents about the disenfranchised grief, a concept that you saw illustrated in the movie, *Unlocking the Heart of Adoption*.

Large Group Discussion: What is meant by disenfranchised grief?

[Note to Trainer: Allow a few minutes for discussion.]
Kenneth Doka’s notion of *disenfranchised grief* refers to grief not acknowledged by society or perhaps minimized or dismissed as being important. Disenfranchised grief may be experienced by all parties to an adoption. Adoptive parents, for example, may come to adoption following repeated miscarriages that they have kept private, or an adopted child may miss the sights and sounds of her home culture, which are unknown to her new adoptive parents. The concept of disenfranchised grief is particularly powerful in relation to birth parents -- birth mothers who place children for adoption without telling important people in their lives, or birth fathers who learn too late that their child has been placed for adoption.

Evelyn Robinson writes that the grief of relinquishing mothers and fathers fits the definition of disenfranchised grief in several ways (see [http://library.adoption.com/articles/grief-and-disenfranchised-grief.html](http://library.adoption.com/articles/grief-and-disenfranchised-grief.html)):

- The pregnancy and relinquishment were most often kept secret, preventing any open acknowledgment of the loss.
- The grief was not socially supported since the birth mother had placed herself in a position that was unacceptable to society. She was to blame and therefore had no right to mourn.
- The birth mother was an embarrassment to her family and others so the grief could not be publicly mourned. She had to pretend that the birth and loss of her child never happened.
- In a relinquishment situation, the mother-child relationship was not recognized: therefore, the birth mother was not recognized as a legitimate mourner since the loss of her child was not considered real.

As you see from these questions, they are designed for mothers who make adoption plans for their infants. It is important to remember that birth fathers also are involved in making adoption plans and we will talk about them in a moment.

It is also important to recognize that increasingly, mothers and fathers of children in foster care are making the decision to place their children for adoption. Often, in these cases, parents work with the public child welfare agency toward reunification but efforts to safely reunite parents and children are not successful. When agencies work closely with parents about the need for permanency for their children and parents are supported by social workers and their children’s resource parents to make the best decision for their children, parents are able to come to the difficult decision to make an adoption plan for their children. In doing this, parents are able to give “permission” for their children to be adopted, which can provide children with a much easier transition to adoption. This planning avoids the
involuntary of termination of parental rights in court and often lays a foundation for ongoing connections between birth parents and extended family and the adoptive family. We will talk more about ongoing connections in a later session.

As you see on Handout #4.9, some questions that a therapist can explore with a birth mother that relate to disenfranchised grief include:

- Was the decision to place your child (or the removal of your child) something accepted by your family?
- Is adoption considered a desirable situation in your community?
- If you did not feel family or community support, how did that make you feel?

Large Group Discussion: How might we reframe these questions regarding disenfranchised grief for birth mothers and fathers who make an adoption plan for their children in foster care?

Lecture

PACT, An Adoption Alliance -- based in California -- has done extensive work with birth families. Here are some of the key points that PACT makes regarding the losses experienced by birth parents who voluntarily place their children for adoption and for the extended family members of these parents:

- In the last decade, there has been a growing acceptance that a loss occurs for birth parents when adoption takes place. In the past, the emphasis in the adoption process has largely been on the reception of the child into the adoptive family rather than the reciprocal loss of the baby for the birth parents and extended family.
- Adoption relinquishment involves a grief process not unlike other types of grief such as death or separation. There are, however, some significant differences for birth parents, due to the nature of the loss.
Large Group Discussion: What issues might you expect birth parents to experience following adoption?

Lecture

The Grief Process for Birth Parents

PACT describes the stages of the Grief Process for birth parents and extended family members when the birth parents place their child for adoption. This information is summarized for you on Handout #4.10. It addresses issues for birth parents who place their infants for adoption but the information is relevant as well for parents who agree to an adoption plan for their children in foster care. Please review this information on your own.

Handout #4.10 PACT: Stages of the Grief Process for Birth Parents and Extended Family Members

Voluntary relinquishment or involuntary termination of parental rights can lead to feelings of anger, shame, humiliation, guilt, and sadness. This can be exacerbated by inadequate social acknowledgment and support for the loss.

Large Group Discussion: What losses might a birth mother or father whose parental rights are involuntarily terminated experience? Let’s consider the following case example:

LuAnn’s two children, Jake (age 4) and Jeremy (age 5), entered foster care two years after LuAnn left them alone in the apartment for three days. A neighbor heard the children crying and called
child protective services. LuAnn has serious substance abuse issues and had planned to return to the apartment but had gotten high then physically sick and stayed with a friend. She lost track of time. Since the children have been in foster care, she has not succeeded in completing a substance abuse treatment program and has continued to blame the neighbor for the fact that the children came into foster care. She continues to ask for more time to make changes so that she can have her children returned to her. After working with LuAnn for 15 months, the agency files a petition to terminate parental rights. LuAnn attempts to fight the termination but the court terminates her rights as a parent.

**Question for Discussion:** What losses might LuAnn experience?

*Raise the following if not mentioned:*

- Loss of the two children accompanied by a range of possible emotions:
  - Shame that the state has intervened
  - Anger that the state has forced the loss of her child upon her
  - Guilt that she was not a good mother
- Loss of social stature as a parent – she is now a “childless mother”
- Should she be allowed ongoing contact with her children, repeated sense of loss as the children return to the adoptive family

**Handout #4.11  Ohio Child Welfare Training Program: Birth Parent Grief and Loss Rights are Involuntarily Terminated**

Look at Handout #4.11. These materials were prepared by the Ohio Child Welfare Training Program and address the stages of grief and loss for parents whose rights are involuntarily terminated and the factors impacting their mourning.

**Small Group Discussion**

*Note: Assign each group one of the stages of grief or the factors impacting mourning. Ask them to address the question following each of these parts of the handout. The assignments are:*

1. Shock/denial
2. Anger/protest

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3. Bargaining and Depression
4. Resolution
5. Factors that can interfere with mourning

Note: Ask each group to briefly review the section of the handout they addressed and then report out on their discussion in response to the “for discussion” questions.

Evidence-Based Assessment

When working with birth parents, it may be useful to administer a standardized screening measure such as the evidence-based Brief Symptom Inventory. This is a checklist of 53 common symptoms and yields scores on generalized distress and well as specific scores on depression and other forms of distress. There are clinical norms for this instrument which can guide the therapist in planning treatment and determining whether consultation might be needed. Information on ordering the Brief Symptom Inventory can be found at:

Information about the evidence base for this tool can be found in the resource, *Evidence-Based Social Work Practice with Families: A Lifespan Approach* by Jacqueline Corcoran.

Lecture

It is important that we recognize that birth fathers – often completely ignored in the adoption process -- experience loss and grief. Handout #4.12 provides an account written by an adopted person of her birth father’s grief and loss.
Handout #4.12  My Birth Father’s Legitimate Grief

Lecture

Let’s look at a short portion of the account. Prior to this part of the account, the young adoptee’s birth father, a senior in high school, agreed with the birth mother that the baby would be placed for adoption. Would someone volunteer to read what the adopted person says about her birth father’s life after the baby was placed for adoption, beginning here:

The motions were made to complete his senior year, yet something had changed that would never be the same. The loss loomed, indescribable and not talked about. Resuming the relationship, yet forever changed, my birth parents were not prepared for the change or for the loss of someone they had both created. "The Baby" was talked about more before and less afterwards. The assumed plan was to resume life as it was, put "it" (ME) behind them. So they both tried to go forward, trying to grasp the illusion that this relinquishment and adoption plan was a one-time event. They gradually drifted apart, growing apart, unable to fill the void now open that they did not know how to work on, at that time.

My birth father now sees that he became more aloof to attaching, became more busy, and used a wall of anger to hide the vulnerable pain, loss and guilt he felt. He underachieved, yet kept highly active physically in various sports "to keep moving." He distanced himself in relationships in his younger years. He and his buddies took risks together and did everything they could at a high energy pace.

As he grew older he became an over-achiever, in some ways making up for the younger years. He has felt lonely at times and melancholy, knowing there were losses. He deeply buried these losses, but they would surface in the form of certain defenses to protect him from feeling the guilt and vulnerability of the pain.
Large Group Discussion: What types of loss did this birth father experience? Are these the losses that you would expect a birth father to experience?

Lecture

Understanding that all members of the adoptive kinship network come to adoption through loss normalizes loss and grieving. There is nothing inherently pathological about the experience of grief. Clinicians need to understand the losses their clients have experienced and how they have dealt with them over time. Intervention becomes necessary when the grief interferes with the client’s functioning.

Clinical Interventions with Birth Parents

There is a range of clinical interventions that can be used to assist birth parents with grief and loss. As we describe these, please share your experiences in using any of the interventions we discuss.

Evidence-Based Interventions

Some of these interventions are evidence-based interventions that specifically focus on depression. The California Evidence-Based Clearinghouse rates the following interventions as well-supported by research evidence. They are rated as having “medium” relevance to child welfare.

Cognitive Therapy (CT) is an intervention for adults with mental health disorders including depression, anger, and anxiety among others. The program is also designed to include family members in the treatment. CT is a form of psychotherapy proven in numerous clinical trials to be effective for a wide variety of disorders. The therapist and client work together as a team to identify and solve problems. Therapists help clients to overcome their difficulties by changing their thinking, behavior, and emotional responses. CT and Cognitive Behavioral Therapy are often used interchangeably. There are, however, numerous subsets of CBT that are narrower in scope than CT: e.g., problem-solving therapy, stress-inoculation therapy, motivational interviewing, dialectical behavior therapy, behavioral modification, exposure and response prevention, etc. Cognitive therapy uses techniques from all these subsets at times, within a cognitive framework. CT was developed by the Academy of Cognitive Therapy’s president, Aaron T. Beck, MD, in the early 1960s.
Interpersonal Psychotherapy (IPT) is an intervention for adults with depression and is also designed to treat the children of a depressed parent. IPT is a time-limited and manual-specified psychotherapy developed initially for patients with major depressive disorder, but later adapted for other disorders and tested in numerous clinical trials. Designed for administration by trained mental health professionals, it can also be taught, with adaptations, to less trained health workers. IPT has been used with and without medication. IPT is based on the idea that the symptoms of depression have multiple causes. The onset of depressive symptoms is usually associated with a trigger in the patient’s current personal life. IPT helps the patient to identify and learn how to deal with those personal problems and to understand their relationship to the onset of symptoms. There are three phases: (1) the diagnostic and problem identification phase where a formulation and treatment contract are made; (2) Identification of the problem area(s): grief, disputes, transition, or deficits, which is the focus of the middle phase; and (3) termination.

Mindfulness-Based Cognitive Therapy (MBCT) is an intervention for adults (between 18-70 years old) who have suffered three or more prior episodes of major depression. MBCT is based on Jon Kabat Zinn’s Stress Reduction program at the University of Massachusetts Medical Center, which was developed to help people suffering with chronic physical pain and disease. It includes simple meditation techniques to help participants become more aware of their experience in the present moment, by tuning in to moment-to-moment changes in the mind and the body. Participants learn the practice of mindfulness meditation through a course of eight weekly classes (the atmosphere is that of a class, rather than a therapy group) and through daily practice of meditation skills while listening to tapes at home. MBCT also includes basic education about depression and suicidality, and a number of exercises derived from cognitive therapy. These exercises demonstrate the links between thinking and feeling and demonstrate ways that participants can care for themselves when they notice their mood changing or a crisis threatens to overwhelm them.

Two other interventions have been rated as supported by the research evidence (and also as having medium relevance to child welfare):

Behavioral Activation Treatment for Depression (BATD) is an intervention for depressed adults including those with substance abuse problems. The BATD program’s primary goal is to reduce depressive symptoms. It is aimed at helping clients reconnect with their values across several life areas. It begins with behavioral monitoring of daily activities with an examination of the extent to which the client currently is living according to these values. In moving the client towards this more valued life, BATD uses a structured approach aimed at identifying activities that fit within the client’s values on a daily basis. The program also uses contracts to recruit social support for these efforts. BATD can be conducted individually or in groups. It was designed to be a 10-12 session treatment, but has been shown to be efficacious in shorter durations.

Intensive Short-Term Dynamic Psychotherapy (ISTDP) is an intervention for adults with a broad range of disorders including personality disorders. The basic ISTDP understanding of many psychological disorders is based on attachment and the emotional effects of broken attachments. Interruptions and
trauma to human attachments may cause a cascade of complex emotions which may become blocked and avoided. When later life events stir up these feelings, anxiety and emotional defenses may be activated. These reactions may be totally unconscious to the person having them, and the result is ruined relationships, physical symptoms, and a range of psychiatric symptoms. A proportion of all patients with anxiety, depression, substance use, and interpersonal problems have this emotional blockage problem. ISTDP focuses on emotional awareness and the ability to feel these emotions in order to heal.

Finally, one intervention has been rated as having promising research evidence (and medium relevance to child welfare):

**Cognitive Behavioral Analysis System of Psychotherapy (CBASP)** is an intervention for chronically depressed adults. CBASP has been developed solely for the treatment of the chronic depressive adults. Most patients present with maltreatment developmental histories that thwart normal cognitive-emotive maturational growth in the social-interpersonal domain. Hence, patients begin treatment functioning in a primitive (preoperational) manner meaning their cognitive-emotional patterns are diffuse, prelogical, ego-centric, global, and they talk to therapists in a monologic manner. Chronic depression is essentially a chronic mood disorder and does not fit the typical Beckian description of episodic major depression as a "thinking disorder." The disorder is driven by an interpersonal fear (mood) and is characterized by generalized interpersonal avoidance behavior stemming from earlier developmental maltreatment. At the outset of psychotherapy, the patient is interpersonally detached and withdrawn and is perceptually disconnected from the actual consequences of their own behavior. The general fiction they live out is “it doesn’t matter what I do, nothing will change.” Three techniques are administered to demonstrate to patients that the way they behave with others has discernible interpersonal consequences (Situational Analysis); to help patients discriminate the psychotherapist from toxic Significant Others who have hurt them (Interpersonal Discrimination Exercise); and to modify in-session maladaptive behavior that precludes the therapist from administering treatment (Contingent Personal Responsivity). The CBASP therapist role is interpersonally active and administered in a disciplined personal involved manner.

**Other Interventions**

Let’s look at four other interventions with birth parents: written role play, therapeutic rituals, journaling, and group work.

**Written Role Play**

As you experienced with your previous assignment with older children and youth, written role play is a strategy for facilitating the birth parent’s exploration of hopes, fears, beliefs, and expectations in relation to the child and adoptive family. The client chooses an adoptive family member to write to. Most likely, this will be the child, but it might also be the child’s adoptive mother or father. (It is not intended that the letter will ever be sent.) The therapist asks the client to write whatever he/she wants
to that person – it can be done in the session or outside. Next, the therapist asks the client to assume the role of the person who has received the letter, and respond in writing as if she/he were that person. Next, the therapist asks the client respond in writing to the response of the adoptive family member, and so on. As with older children and youth, this process is “correspondence with the self.”

**Therapeutic Writing**

For birth parents who are comfortable with written expression, journaling can be a very helpful outlet for feelings and provide a source of insight. There are many books available about different forms of journaling. Some styles of journaling are very free-flowing, and others are very structured. Choose a method that is comfortable for your client. There is a growing body of research showing that writing can have therapeutic benefits that help psychologically as well as physically (through reduction of stress hormones, for example). As therapy progresses, it is useful to have the client return to material written weeks earlier to revisit those feelings in light of therapeutic progress made since then.

An example of therapeutic writing  is in Handout #4.13. Please read Elizabeth’s writings on your own.

**Handout #4.13  Elizabeth**

**Therapeutic Rituals**

Rituals are symbolic acts that provide support for people and provide an environment for expressing and containing strong feelings. They are a means of connecting the past to the present, and the present to the future. The experience of birth and adoptive families has shown that rituals can provide a powerful bridge to adoption. Rituals celebrated with openness, love, and pride send a powerful message of validation to those around us, and most importantly, to the child entering the family.

The outcomes of rituals may be:

- The child releases feelings of grief, anger and confusion toward a situation or person
- The child is able to put memories in a safe place so that they do not interfere with connecting with her new family
- Family relationships are clearly defined
- People are joined together in new roles

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Parents’ feelings of entitlement are strengthened

One powerful type of ritual is the entrustment ritual. In this type of ritual, the birth mother (possibly accompanied by her extended family, friends, or supporters) physically places the child with the adoptive parents. This may be done in the context of a religious ceremony where prayers are said; it may be an opportunity for taking photos and having conversations about the future. It will surely involve the expression of strong emotions.

Your prior work with a birth parent should suggest areas of “unfinished business” for which a ritual might be helpful. For example, if the child has died but the birth parent was not able to participate in the funeral, it might be useful to have a ritual marking the child’s passing. If it is clear that the birth parent will never be able to see the child, it might be helpful to develop a ritual of “letting go,” so that he/she can have some peace about that.

Rituals marking a transition from the past to the future will probably be most useful. For example, if the birth parent has begun a new life through marriage, partnering, or having more children, it might be helpful to develop a ritual celebrating this new life, while also acknowledging the sadness of another life left behind. Use your creativity, and involve the birth parent in planning the ritual. As you are doing this, take into consideration the role of ritual in the birth parent’s current life and in any faith tradition he/she might adhere to.

Let’s look at an example of the use of a therapeutic ritual with a birth mother. Please look at Handout #4.14.

Handout #4.14  Emily

Note to Trainer: Ask for volunteers to read each section. Prop needed: baby doll.

Volunteer #1:
Emily is a 22 year old single woman who got pregnant during her first year of graduate study. Believing she was not prepared to raise a child, she contacted an adoption agency to make an adoption plan for her child. She indicated a desire for an open placement and eventually chose a lesbian couple, Sharon and Natalie, as the adoptive parents. The following ritual took place at the adoptive parents’ home, a week after the birth of the child. Guidelines for the ritual had been provided by a clinical social worker who consulted with the parties prior to and following the adoption. The social worker was present to help facilitate the ritual. Also present were Emily’s parents and the parents of Sharon and Natalie.

Note to trainer: Ask for volunteers to read the part of Emily, Sharon and Natalie. Note that the dialogue is a description of the ritual, paraphrasing what was said and done by the parties.
Emily [holding her child in her arms]: This is both a sad and joyous time for me ... I am very sad not to be able to be a parent to Mia ... to raise her and be with her all the time as she grows up ... and not to be able to have my mom and dad be her grandparents like they thought they would be ... but it’s just not possible ... it would be selfish to try and raise her when I’m not prepared to do so ... But I’m also happy too ... I’m happy to have found two wonderful people to be Mia’s parents ... Sharon and Natalie. So I’m here today to say to the two of you that I give you my love and my blessings and I ask you to be Mia’s parents and to help her grow up as a happy and healthy child ... I am also grateful to have found two people who are willing to allow me and my parents to also be part of Mia’s life as she grows up ... She will have the best of all of us. [Emily hands Mia to Sharon]

Sharon [holding Mia]: Emily, this is also a sad and joyous time for us too. In witnessing your sadness, we feel it too. And we are here to help you in any way we can ... I will be forever amazed and grateful for your generosity of spirit, for your love, and for the unbelievably beautiful baby that you have bestowed on us. I only hope that we prove worthy of this cherished gift. I want to say to you today that we have not only taken Mia into our hearts, but you and your family as well. I promise you that I will do everything within my power to raise Mia with love, gentleness and empathy, and to make sure that she not only knows you, but also comes to realize our love and respect for you and your parents. [Sharon hands Mia to Natalie]

Natalie [holding Mia]: I am so overwhelmed by what is happening. I feel so much love for you Emily and I cannot adequately tell you all that is inside me ... I also promise you that Mia will have a home with us that is filled with love and respect ... and she will also understand that she has two families, ours and yours. That I promise.

Note to Trainer: Ask another volunteer to read the following and the words of the social worker:

All the parties, including the grandparents, were asked to bring a distinctive piece of cloth, approximately 2 inches wide by 12 inches long. Emily also was asked to bring a similar piece for Mia. At this point, the social worker asked Emily’s parents to tie their two pieces together (representing the birth parents’ marital bond); next Emily was asked to tie her piece of cloth to those of her parents (representing the nuclear birth family); next, Sharon’s parents were asked to tie their pieces of cloth together, followed by Sharon tying her piece to those of her parents (representing her nuclear family); a similar process was followed for Natalie and her parents (representing her nuclear family); next Sharon and Natalie were asked to tie the pieces representing their nuclear families together (representing their joined families); finally, Emily, Sharon, and Natalie were asked to tie Mia’s piece of cloth to the ends of their respective families and to bring the other ends together forming a circle (representing the
connection between the birth and adoptive families); the cloth was then passed to the social worker who asked everyone to gather together, holding a part of the circle of cloth that represented their family.

Social Worker: This circle of cloth, created by all the people here today, with love and respect for one another, represents the unbroken and eternal connection between Mia’s origins and her future, between the family that made her and the family that will raise her. She will come to know herself and be strengthened through both families.

Questions for Discussion

• What do you see as the purpose of an entrustment ritual?

• How does this type of ritual benefit both the birth parent and the adoptive parents?

• What are some of the ethical issues that must be considered in helping to facilitate such a ritual?

Group Work

Being a birth parent is an isolating experience. It is often accompanied by feelings of shame and guilt, and the birth parent may not willingly share this experience with others. Some birth parents who present clinically may have never spoken about it with anyone since the placement. Some may not have revealed it to current loved ones, even spouses or children. Therefore, “talk therapy” can be very beneficial, but talking within the safety of a group of other birth parents might be even more useful. In such a group, clients learn that their feelings and experiences are not unique or extreme – others have had similar reactions, feelings, and experiences. Depending on your practice, this could evolve into an ongoing support group. Although a support group need not be overtly therapeutic, there are likely to be therapeutic benefits for participants.

4:15PM – 4:30PM Summary and Closing

We are reaching the end of our session today. Please ask yourselves whether you can:

  o Describe three ways that loss, grief, and separation impact adopted children, birth parents, and adoptive families and kin and give examples of each.
  o Describe four different ways that children express grief.
- List the four psychological task of the Good Grief Model.
- Describe two ways that a therapist can provide a safe, supportive and confidential environment for adoption and children and youth.
- Demonstrate two clinical interventions in working with adopted children and youth to help them process their grief and loss.
- Identify three types of losses that adoptive parents may experience after the adoption.
- Describe two clinical interventions in working with a birth parent to process the experience of relinquishment/termination of parental rights and adoption.

As a result of this session, you should be able to answer “yes” to each of these questions. If not, please feel free to talk with me after the session and please review the session materials.

In your email inbox, you will find a message with a link to a brief online survey for you to provided feedback on today’s workshop. It will ask you to rate the quality and relevance of the workshop content and the effectiveness of the learning activities, to identify the strengths of the training session, and to recommend ways that the training can be improved. Please follow the link in the email and provide the feedback right away while the session experience is fresh in your memory.

You will also receive an email directing to you to the “test” on this session. This “test” is designed to help you and me assess what you have learned from the session today.

Thank you for your attention. In our next session, we will focus specifically on trauma and brain neurobiology. Please go to the website for your pre-session assignments.
Reading List

Additional Recommended Readings


Web-Based Resources


Other Resources


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Neil, E. & Howe, D. (Eds.), *Contact in adoption and permanent foster care*. London: BAAF


**Research on Group Therapy for Adolescents/Cohesion**


Module #4. Clinical Issues in Providing Therapeutic Services: Grief, Loss, and Separation

Handouts
Handout #4.1 Kubler Ross Stages of Grief

Elisabeth Kubler-Ross has been a pioneer in the field of death and dying research. In her work with dying people and those close to them, she has identified five stages of the normal grieving process. These five stages can be worked through in any order. Some stages may be revisited, but typically people pass through all five stages in their processing of grief issues.

Denial: The first stage of grieving is denial. Feeling shock, disbelief, numb, and detached is common. The incident or feelings are kept out of one's awareness. Denial is protective in that it helps people to function when the truth or clarity would be too much to handle. Staying in denial, however, has negative consequences. To ignore important issues and feelings is like having a pink elephant in the living room that no one talks about. Everyone walks around it and pretends it isn't there even though it's in the way of everything.

Anger: The second stage of grieving is anger. Anger is the feeling that a situation is unfair and should not have happened. It is common in the anger stage to look for someone to blame. Anger can also be very motivating and inspire one to take action. The anger stage can help a person make changes in their life.

Bargaining: The third stage of grieving is bargaining. Bargaining involves trying to find ways to undo the situation by searching for trade-offs. Being in the stage of bargaining means that the person is no longer in denial. There is a real awareness of the loss, and the bargaining is an attempt to control a situation that feels out of control.

Depression: The fourth stage of grieving is depression. Feelings of helplessness and hopelessness can be present as well as a lack of energy, changes in eating or sleeping patterns, irritability, lack of interest in usual activities, sadness, and an inability to concentrate.

Acceptance: The fifth and final stage of grieving is acceptance. The loss is no longer the main focus and there is room for other activities and interests. The goal of acceptance is not to forget as that would bring one back to the stage of denial. In adoption, the goal of acceptance is to honor and integrate the people and experience of adoption.
Loss: A feeling of emotional deprivation that is experienced at some point in time. For a birth parent the initial loss will usually be felt at or subsequent to the placement of the child. Adoptive parents who are infertile feel a loss in their inability to bear a child. An adopted child may feel a sense of loss at various points in time; the first time the child realizes he is adopted may invoke a strong sense of loss for his birth family. (From http://glossary.adoption.com/loss.html)


Four Questions about Ambiguous Loss:

1) How does it differ from ordinary loss?

Ambiguous loss differs from ordinary loss in that there is no verification of death or no certainty that the person will come back or return to the way they used to be.

2) Why does it matter?

Ambiguous loss freezes the grief process and prevents closure, paralyzing couple and family functioning. For more information, please refer to Pauline's books, "Ambiguous Loss" and her most recent book, "Loss, Trauma, and Resilience".

3) How does one ease its effects?

The six guidelines for resiliency while having to live with ambiguous loss are detailed in, "Loss, Trauma, and Resilience". As described in Dr. Boss's cyclical model, they are:

   Finding Meaning
   Tempering Mastery
   Reconstructing Identity
   Normalizing Ambivalence
   Revising Attachment
   Discovering Hope

4) What are the types of ambiguous loss?

There are two types of ambiguous loss situations.

Type One occurs when there is physical absence and psychological presence. These include situations when a loved one is physically missing or bodily gone. Catastrophic examples of such ambiguous losses include kidnapping and missing bodies in the context of war, terrorism ethnic cleansing, genocide, or natural disasters such as earthquake, flood, and tsunami. More common examples of this type of ambiguous loss are situations of absent parents due to divorce, giving up a baby to adoption, and physical contact with parents and siblings due to immigration.
In **Type Two**, there is physical presence and psychological absence. In this type of ambiguous loss, the person you care about is psychologically absent— that is, emotionally or cognitively missing. Such ambiguous loss can occur from Alzheimer’s disease and other dementias; traumatic brain injury; AIDS, autism, depression, addiction, or other chronic mental or physical illnesses that take a loved one's mind or memory away.

**GRIEF**

*Grief:* A deep feeling of emotional loss. In the context of adoption, grief may be experienced by any or all of the members of the adoption triad at any time in their lives and to varying degrees, as well as by individuals who are collaterally involved in the adoption process, including siblings, spouses, after-born children, foster parents and other caregivers or related individuals. (From [http://glossary.adoption.com/grief.html](http://glossary.adoption.com/grief.html))

**Disenfranchised Grief:** A concept developed by Kenneth Doka to refer to grief not acknowledged by society.
Case Examples: Adopted Children’s Experiences of Loss

Case #1  Sam and Terry, a white couple from Minnesota, adopted Amanda from China when she was age 18 months old. She had been left by the side of the road and was found by a family who took her to an orphanage. Amanda is now 10 years old.

Case #2  Sonita adopted Cassandra, a thirteen year old, from the foster care system. Sonita is Latino; Cassandra is African American and Native American. Cassandra has an older brother who aged out of foster care two years ago. She does not know where he is.

Case #3  Betty adopted Brian as an infant. He is now 8 years old. Betty lives in Connecticut; Brian’s birth mother lives in Montana. Betty knows that Brian has two older sisters by birth who have a different father than Brian. Brian’s birth mother told Betty that she just didn’t think that she could handle a boy on her own. Brian’s birth father had minimal contact with Brian before the adoption and has not contacted Betty since she adopted Brian.

Case #4  Lori and Tammy adopted 8 year old Shonisha from foster care. They live in California; Shonisha was in foster care in Florida where she had lived with the same for three years and had attended the same school since kindergarten. When she was in Florida, her maternal grandmother visited her often.

Case #5  Beth adopted Tanika at age 14 from foster care. She is now 18 years old. Tanika has two younger sisters (Dominique and Tami) who were adopted by a different family before Tanika was adopted. When they were with their birth parents, Tanika was the one who took care of the younger girls. When they entered foster care, she was separated from them and then they were adopted. She continues to have some contact with them but she feels that the relationship has changed.
The Good Grief Program of Boston Medical Center

What Do Children Need?

1. Children need love, care, consistency, continuity and connection.

2. Children need to feel safe in the world.

3. Children need to know that there are people in their lives who are there for them.

4. Children need to be allowed to grieve. We should be there for them as they experience their pain instead of trying to hide the death or shield them from the pain.

5. Children need us to respect where they are in their grief. All feelings should be validated. Everyone grieves in their own way and in their own time. Loss involves not only the death of the loved one but the changes in life because of the loss.

6. Children need simple, truthful, age-appropriate information. Too much information can be confusing. Find out what they know. Allow them to ask the questions that they want answered.

7. Children need us to listen to them carefully so we may understand how they are feeling and to be able to clear up fears, misconceptions or misinformation.

8. Children need us to know that they want to be included, not excluded from the truth.

9. Children need us to be authentic and share our feelings with them also. They learn by watching how we deal with loss.

10. Children need us to help them keep a connection with their loved one who has died. Give them the opportunity to remember and share your memories with them also.

11. Children need us to know that they grieve sporadically and will re-grieve the loss through each developmental stage.

12. Children need us to challenge magical thinking.

13. Children need us to help them understand that going-on does not mean forgetting or loving the person who died any less. Going-on honors the person who died because as long as we remember, the memories never die.

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Handout #4.5  Alicia

Alicia, a spirited 15-year-old, adopted from Guatemala when she was 6 years old. She recently took a drug overdose at school. After she physically recovered, she comes with her mother and father to see you. She quickly informs everyone that she has no intention of saying anything and the whole thing “is a big waste of time.” Her parents report that Alicia’s hostility has been growing. After she was expelled from public school for drug use, her parents enrolled her in a private school but it is uncertain whether the private school will allow her to remain. Alicia says that she couldn’t care less. You ask the parents to describe why Alicia is being referred for therapy and then ask them to wait in the waiting room.

**Question #1.** Now alone with Alicia, you face her anger. She immediately says, “I’m tired of coming to this kind of thing – you are just like the rest of them – I want to leave.” How would you respond to Alicia?

**Question #2.** When you acknowledge her anger and reflect on her need to self-medicate her pain, Alicia snaps, “Why do you give a shit what I do with my anger? It’s not your problem.” How would you respond?

**Question #3.** You acknowledge that she is correct and add, “But it certainly seems to be a problem for you – we wouldn’t be sitting here together if it weren’t. You know, I have seen lots of teenagers who are adopted and have very strong feelings about their adoption experience and sometimes difficult, painful things have happened to them.” Alicia just glares at you. How would you respond?

**Question #4.** Alicia blurts out, “You would be pissed too if you had to leave your little brother at the orphanage and never said good bye.” What tentative conclusions are you drawing at this point?

**Question #5.** After talking with Alicia, you invite her parents to rejoin you in the session. What would you want to share with the parents at this point?
### Handout #4.6  CASE Scripted Group Schedule: Group Therapy with Teens

The following is the scripted group schedule that CASE uses with teens:

<table>
<thead>
<tr>
<th>Week</th>
<th>Topic</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Getting to know one another</td>
<td>Exploration of similarities and differences among our families and ourselves</td>
</tr>
<tr>
<td>Two</td>
<td>My Adoption Story</td>
<td>Through a creative art project, teens create their adoption story to share with the group. The purpose is to help the teen ascertain what information they do have and identify aspects of their story that need further elaboration and/or clarification.</td>
</tr>
<tr>
<td>Three</td>
<td>Emotions and Feelings</td>
<td>&quot;Sometimes I feel happy, sad, and angry at the same time.&quot; Teens are encouraged to share the varying feelings they hold within themselves and to learn healthy ways to communicate these feelings.</td>
</tr>
<tr>
<td>Four</td>
<td>Birth Parents</td>
<td>Teens are encouraged as a group to create a &quot;puzzle&quot; of questions that they would like to have their birth parents answer.</td>
</tr>
<tr>
<td>Five</td>
<td>Birth Parents, Part 2</td>
<td>Teens grapple with the relinquishment decision during adolescence. In order to gain a deeper understanding as to the complexities of this decision, teens read together <em>The Mulberry Bird</em> by Anne Brodzinsky (1996).</td>
</tr>
<tr>
<td>Six</td>
<td>Identity</td>
<td>Through the use of the Game of Discovery, an interactive exercise created especially for adoptees, teens understand that their identity is based upon characteristics from their birth parents, adoptive parents and self. NOTE: This tool is currently being finalized and is not available at this time for distribution.</td>
</tr>
<tr>
<td>Seven</td>
<td>Identity, Part 2</td>
<td>Mask Making: What do we show on the outside and what do we keep in the inside?</td>
</tr>
<tr>
<td>Eight</td>
<td>Relationships</td>
<td>Fears of intimacy related to abandonment and rejection often affect the teen’s ability to establish and maintain healthy peer relationships.</td>
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<tr>
<td>--------</td>
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<td>----------------------------------</td>
</tr>
<tr>
<td>Ten</td>
<td>W.I.S.E. Up!</td>
<td>Participants are taught this program to empower them with choices as to how they respond to questions from peers, neighbors and others.</td>
</tr>
<tr>
<td>Eleven</td>
<td>Family Night (optional, depending on the group)</td>
<td>This is an opportunity for teens to share with their parents highlights of adoption issues that were important to them over the course of the group. Also, it is an opportunity in a safe, structured environment for teens to acknowledge the importance of these issues in their life.</td>
</tr>
</tbody>
</table>
Handout #4.7  Amy

Amy is a 15 year old female, adopted domestically soon after birth. Her birth mother indicated no desire for contact with the adoptive family at the time of placement. Amy lives with her adoptive parents and a younger sister who was born to her parents. She was referred initially to therapy at 9 years of age because of depression and defiant behavior at home. After 14 months of treatment, her symptoms were substantially reduced and she was discharged from therapy. Just prior to her 15th birthday, Amy asked to return to therapy because of self-esteem issues and social problems. She also was interested in her biological origins and wanted to make contact with her birth relatives. Her adoptive parents had very little information about her birth family but indicated a willingness to help Amy search for members of the birth family. As part of the treatment, her therapist encouraged Amy to write letters to her birth mother and to answer those letters as if her birth mother had received her letters and was writing back to her.

The following are samples of some of her letters:

Dear

I hope you remember me. I am your daughter who you gave up for adoption when I was just born. I’m 15 now and I want to know who you are ... I’ve thought a lot about you since I was little and kind of imagined what you look like. I think you probably have blonde hair because I’m blond ... and you are probably tall too, like me. But what I really want to know is why you didn’t keep me ... I keep thinking about it over and over and I don’t know why and I want to know why. So if I could meet you, that’s what I would ask you.

xxoo
Amy

Dear Amy,

I don’t know what to say to you. I don’t know what you want to know and I don’t know if I can answer your question ... It was a long time ago ... you probably think I didn’t want you but that’s not true ... I just couldn’t raise you and you needed someone who could do it ... I couldn’t. I don’t want you to be sad about it.

xxoo

Dear

I’m not sad about being adopted but I am sad about not knowing who you are ... it feels like part of me was left behind with you and unless I find that part then I won’t know who I am ... that’s why I want to find you and my birth father too ... then I can know who I am ...

Dear Amy,

I understand what you said ... about part of you being left behind and not knowing who you are ... when we meet you will see who I am and then you will know who you are too ...

xxoo

[Four months later, after her adoptive parents contacted the adoption agency and were given updated information forwarded by the birth mother, Amy writes the following.]
Dear

I was so happy to get the letter you sent to the adoption agency. I can’t wait until I’m 18 so that the people at the agency will help me meet you. I was surprised that you had another child who was older than me and who was adopted too … It made me realize that your decision to have me adopted wasn’t because you didn’t want me but because you weren’t ready to be a mom to either of us ...

The things you described about yourself were like you were describing me … loving music and dancing, being bad at math but liking reading, and being shy with people. You mentioned having dogs. We don’t have dogs but we have three cats, so I guess we both love animals too. And I think we probably look alike too because we’re both have long blond hair.

I wish I knew my older brother and where he is … Do you know who adopted him? I have a younger sister but we fight a lot. I’ve been jealous of her too because she isn’t adopted. She doesn’t know what it’s like to not know her the people who made her. It’s not her fault, but it still makes me mad that I don’t know you but she knows her mom.

At first I was confused when you said that you hoped that I loved my parents. I thought you meant you and my birth dad. But then I realized you meant the parents who raised me. I do love them … even though we argue a lot. They’re really good parents. And they understand how I feel about being adopted and they still love me and want to help me find you … I’m not looking for different parents … they know that … I just want to find you and get to know you and figure out why it had to happen that you couldn’t keep me.

xxoo
Amy
Handout #4.8 Adoptive Parent Losses: Case Examples

CASE #1: Beth adopted a two-year-old girl from Russia. Her daughter, Allie, has had a difficult time adjusting to life in her new family. Allie refuses to be comforted and flinches when Beth tries to put her arms around her.

CASE #2: At the same time that Katie adopted a two year old boy from Columbia, her sister Sissy gave birth to a little boy. At age twelve, Sissy’s child is a “chip off the old block” – smart and with a talent for softball, just like his grandfather. Katie’s son, Kenneth, hates sports and refuses to play. He is not doing well in school.

CASE #3: Mack and Mira adopted Evan from foster care at age 8. They were told that he had physical health problems, including asthma and a history of rheumatic fever, and whooping cough. Since adopting Evan 2 years ago, Evan has experienced chronic skin rashes, chronic ear aches, ongoing dental problems, and repeated respiratory crises. Mack and Mira feel “worn down.” When they come in to talk with the therapist, they reveal that they experienced 4 miscarriages before they adopted Evan.

CASE #4: Donna, a single adopted mom of 16-year-old Cami, underwent unsuccessful infertility treatment for two years before deciding to adopt Cami at age 8 from foster care. Cami is now openly expressing her sexuality and Donna is depressed and anxious almost all of the time.
Handout #4.9 Obtaining Background Information from Birth Parents On Physical and Psychological Contact with their Child and Disenfranchised Grief

Physical Contact

The following questions should be applicable both to birth parents whose children were removed by the courts and children who were voluntarily relinquished.

- Have you had any contact with your child or child’s adoptive family since placement?
- If so, when? how frequently? with whom?
- Is the contact continuing? If not, why?
- How have the most recent visits gone? Please tell me about your last visit.
- If there is not ongoing contact, are you able to re-establish it if you want?
- Is there an agreement now with the adoptive family regarding contact? verbal or written?
- What would your ideal contact situation be, for right now?
- What are the factors standing in the way of this ideal situation?
- Does your child or the child’s adoptive family have a different idea about contact than you do?
- Is anyone else from your family involved in the contact? (your partner, other children, parents, other birth relatives, etc.)
- How does that go?

Psychological Presence/Absence

Questions such as the following should be asked of birth parents about the psychological presence or absence of their children.

- How often do you think about the child you placed for adoption?
- Do you have dreams or daydreams?
- If so, what are they like? (explore emotional qualities attached to dreams or daydreams: happy memories, frightening, sad, etc.)
- Are there certain times of the year when you experience this loss more keenly? If so, when, and what do you do? (Many birth parents report such thoughts on the child’s birthday, major holidays such as Christmas, and Mother’s Day.)

For Discussion:

Discuss and prepare to report out:

3. How would you work with a birth parent who tells you that she thinks about her child every day and often has happy daydreams about seeing him again, only to then feel extremely sad? Her parental rights were involuntarily terminated by the court. Her child, age 10, was adopted by a family in another state and she has had no physical contact with him.
4. How would you work with a birth father who, while incarcerated, voluntarily relinquished his rights to his 14 year old son after the mother’s rights were involuntarily terminated. He was released from prison 6 months ago. He describes intense sadness on his son’s birthday and periodic dreams in which his son is crying as he is led off to prison. He does not have physical contact with his child, though the agency has not closed the door on contact if the adoptive parents agree.

Disenfranchised Grief

Here are some questions that a therapist can explore with a birth parent:

- Was the decision to place your child (or the removal of your child) something accepted by your family?
- Is adoption considered a desirable situation in your community?
- If you did not feel family or community support, how did that make you feel?
Handout #4.10  PACT: Stages of the Grief Process for Birth Parents and Extended Family Members

Numbness and Denial: During the initial phase of grief, the birth mother is trying to cope with the realization that the birth has become a reality. In the midst of the physical and emotional strain of having given birth, she faces the decision of relinquishment and the loss this decision involves, all in a very short space of time. Denial is a very primitive defense mechanism which can be effective in protecting a person from emotional collapse. Denial may have been a mechanism the birth mother utilized to cope during the pregnancy. Defenses such as denial need to be respected.

1. Eruption of Feelings: As the shock and confusion lessen and the denial or numbness recedes, floods of intense feeling may erupt without specific triggering events; this eruption can be an overwhelming experience involving a range of feelings such as sadness, emptiness, anger, fear, panic, anxiety, despair, guilt, shame, helplessness, hopelessness, loneliness, irritability, fatigue, or difficulty concentrating. Feelings might get expressed indirectly through physical symptoms. Secrecy, shame and lack of public acknowledgment of the loss by family, friends and society mean that the fact of the loss is never validated. What follows, then, is a subsequent lack of natural opportunities for expression of feelings and therefore diminished opportunities for support.

2. Accepting the Adoption Decision: The fact that the adoption process involves a birth mother's active choice in determining the course of events sets this loss apart from other losses such as death, aligning it instead to the loss experienced when an individual decides to separate from a spouse. In a marital separation, the initiating spouse is motivated to the decision because of some type of untenable situation and may feel anger toward the spouse, allowing emotional distance. In contrast, the decision resulting in loss of an innocent baby or child only brings sadness and guilt, even when others try to reinforce that it is "in the best interests" of the child and that the child will be "loved." The love of others for the child does not cancel out the pain of the loss for the birth parents.

3. Accommodation to and Living with Uncertainty: If feelings are granted expression, then the feelings gradually become more manageable, and emotional reactions are in manageable response to natural reminders of the loss. Birth parents can find ways to live with the repeatedly sensitive areas: the child’s birthdays, others’ pregnancies, their own future pregnancies, baby showers, meeting children with the same name, and other losses. Birth parents have to find ways to answer such questions as, "Don’t you want to have any children?" or "You’ll know what being separated from a child is like when you have children of your own." Birth mothers listen in silent pain to other women's stories of labor and delivery, often unable to join in this connecting female discussion.

4. Reevaluating and Rebuilding: The secrecy, shame, guilt, self-blame, feelings of selfishness and loss leave scars on birth mothers' self-esteem. Birth parents may struggle as they reevaluate their decisions later in life. Birth parents might feel incapable of making decisions, feel unlovable, or feel unable to handle having another child. At such moments, they need to realize that they made the decision at a particular time and place, perhaps as a vulnerable teenager without adult skills or resources. Restoring self-esteem is an ongoing process, and rebuilding self-esteem also depends on the degree of self-esteem possessed prior to the pregnancy crisis and relinquishment.
Behavioral Expressions of Grief and Loss in Parents Whose Rights are Terminated Involuntarily

Certain behaviors typify family members’ response to the losses and threats experienced during the placement of a child in foster care. As the child’s custody moves from temporary to permanent placement, it is important that workers understand the typical behaviors found in parents whose children are lost to them due to termination of parental rights.

**Shock/Denial Stage**

- Parents may exhibit a robot-like, stunned response at the move. They may be immobilized. A characteristic response of people in emotional shock is, "This can't be really happening!"
- Parents may be very compliant, and may express little emotion or affect. They may appear bland, uncaring, or uninvolved.
- Parents may deny that there is a problem, or deny that the agency can remove the children. They may insist the children will be home in a day or so, or that, "No court will ever give you custody."
- Parents may avoid the caseworker and deny the need to be involved with the agency.
- Some parents who do not have close attachments to their children may not exhibit strong emotional reactions when their children are removed from them. These parents may have abandoned their children or left them in the care of others for long periods of time in the past. The caseworker should assess the parents’ reactions over a period of time to differentiate the immobility typical of the shock stage from the emotional remoteness of parents who lack a strong attachment to their child. Parents in shock will move within a few hours or days to expressing anger and pain. Parents without close attachments often do not.

*For Discussion:* If the public child welfare agency referred a parent to you whose child has entered foster care and your behavior is described as “immobile,” how might you work with the parent?

**Anger/Protest Stage**

- Parents may threaten court action or may directly threaten the caseworker. They may contact an attorney to fight the agency.
- Parents may behave in a contrary and oppositional manner by refusing to let the caseworker visit the home, or by refusing to talk with the worker.
- Parents may refuse to participate with the worker to develop a case plan or to make decisions about the child’s welfare.
• Parents may become demanding, sometimes making irrational demands on the worker or the agency.

• Parents may blame the agency, the caseworker, the court, the system, the complainant, or others for the existence of the problem. They may vehemently reject any need to change.

Discussion Question: LuAnn, whose case we just read, continued to blame the neighbor for her children entering foster care. If you were working with LuAnn, how would you work with her around this issue?

**Bargaining Stage**

• Parents may become semi-responsive to the caseworker, and may behave more compliantly.

• Parents may make broad promises, such as, "It will never happen again;" "I'll ask my boyfriend to leave;" "If I go to all my parenting classes, will I get my children back?"

**Depression Stage**

• Parents may "forget" or miss appointments with caseworkers, or may fail to attend scheduled visits with the children.

• Parents may exhibit little initiative or follow-through in visitation or other activities designed to promote reunification.

• Parents may display futility and a loss of hope that their children will ever be returned home. Some parents even move away or disappear, and the agency loses contact with them.

For Discussion: You are working with a parent whose children are in foster care. He alternates between urging you to convince the Department that he is motivated to do everything that he needs to do to get his children back and expressing hopelessness that he will succeed. How would you work with him on these issues?

**Resolution Stage**

• Parents may emotionally begin to restructure their lives without the children.

• Parents may move away without notifying the agency, become involved in new relationships, may have other children, or otherwise "get on with life."

• Parents may not respond to their caseworker's attempts to work with them. Parents may stop visiting with their children.

• Parents may not protest court action for permanent custody and may not attend permanent custody court hearings.

For Discussion: You are working with a parent who tells you that she does not think that she will get her children back and that she might as well give up. She tells you that she has a new boyfriend and they are talking about having a baby. She says that she knows that this is her chance to be a mother again. How would work with this parent on this issue?
FACTORS THAT CAN INTERFERE WITH MOURNING

- Lack of acknowledgment of the loss by society, family, friends, and professionals
- Lack of expression of intense feelings
- Not having a mental image of the baby as a result of lack of information or not having seen the baby
- Preoccupation with the fantasy of reunion in such a way as to avoid dealing with the loss
- Preoccupation with searching for something to fill the gap left by the child to avoid facing painful feelings
- Belief that having a choice takes away the right (and need) to grieve
- Feelings of loss even in open adoption (Birth parents may be surprised at the level of their grief in an open adoption.)
- Self-depreciation and self-blame
- Pressure from others to decide on adoption, which makes it difficult to take responsibility/ownership for the decision
- Lack of support
- Numbing through substance abuse
- Maintaining secrecy and not acknowledging the loss to oneself or others

For Discussion: Which of these factors have you seen clients experiencing with respect to adoption or other losses in their lives?
Handout #4.12  My Birth Father’s Legitimate Grief
Source: http://library.adoPTION.com/articles/my-birth-fathers-legitimate-grief.html

A 17-year-old boy, in his October 1962 senior English class, casually jots down what he is daydreaming about on the front page of his high school thesaurus. He writes down three dates: the current date, his birthday and his girlfriend's birthday.

Thirty four years later, in October of 1996, he is excitedly rummaging through high school memorabilia to validate what was reconnecting for him in his heart and soul. Now 52 years old, he opens his high school thesaurus. There, written years earlier, is a confirmation, the three dates. He cannot believe what he is seeing, yet is relieved and ecstatic. He immediately rips the page out, writes an inscription on a note to put beside it, and laminates the page.

This piece, a page out of a thesaurus, is a symbol of my beginnings. The first date, in October 1962, is when my birth father learned he was going to be a father. It confirms for him that, even though he did not give birth to me, he did remember me, and with the innocence of a 17-year-old, somehow muddled through with my birth mother and her pregnancy at age 18.

Later that fall, the decision was made to relinquish me through a private agency in another state. It was thought to be one of the most reputable. My birth parents, aged 17 and 18, were a part of the big discussion; yet in 1962, the decision was a given, rather than a result of options explored fully.

My birth father and birth mother continued to date, and his adoptive mother played a large role in making sure that the plan was carried out, probably thinking all the while that she was minimizing pain and disruption in their young lives.

My birth father watched the reality unfold as my birth mother changed, physically and psychologically, into a woman. By the time she was seven months pregnant, in March 1963, it was time for her to "go away." It was a brisk spring night, and my birth father remembers the sadness, and trying to be funny to lessen the pain that seemed imminent. He remembers feeling me kick and wiggle. For some reason, he was to take his mother and my birth mother to the train, and stayed in the car and waited for over an hour for the train to depart while his mother made arrangements in the train station.

Later, he would send me a watercolor portrait of this train station, etched on the back, "3/63..The End. 1096, The Beginning." In 1997 he would take me to the train station and reiterate that this is where he said goodbye to her, and to me.

My birth parents kept in contact for two months while she was away. He remembers his mother being lenient about the long distance phone calls. He remembers the changes in my birth mother’s voice as the reality of womanhood and having a baby came closer. He felt a lot of regret that he was unable to meet and fulfill what he now knows were the responsibilities of a father and husband. Loss and permanent life changes were in the air.

One day in the middle of May, my father, an avid baseball player, went to play a game in the next town. He remembered getting a hit in a seven-inning game on a beautiful May afternoon. As he arrived home from the
game at about 6:00 PM, on his eighteenth birthday, his mother greeted him with an announcement. Joy was the initial response, yet as it settled, the loss attached quickly to the reality of the announcement.

Congratulations! You are a father, and you have a baby girl.

Restless and confused, he left the house and went to a local tavern. He remembers listening to the Beatles, and trying to take in the event that had just occurred. He had a baby girl, and on his birthday. He too, like my birth mother, had taken a further push out of innocence into adulthood, that birthday.

The motions were made to complete his senior year, yet something had changed that would never be the same. The loss loomed, indescribable and not talked about. Resuming the relationship, yet forever changed, my birth parents were not prepared for the change or for the loss of someone they had both created. "The Baby" was talked about more before and less afterwards. The assumed plan was to resume life as it was, put "it" (ME) behind them. So they both tried to go forward, trying to grasp the illusion that this relinquishment and adoption plan was a one-time event. They gradually drifted apart, growing apart, unable to fill the void now open that they did not know how to work on, at that time.

My birth father now sees that he became more aloof to attaching, became more busy, and used a wall of anger to hide the vulnerable pain, loss and guilt he felt. He underachieved, yet kept highly active physically in various sports "to keep moving." He distanced himself in relationships in his younger years. He and his buddies took risks together and did everything they could at a high energy pace.

As he grew older he became an over-achiever, in some ways making up for the younger years. He has felt lonely at times and melancholy, knowing there were losses. He deeply buried these losses, but they would surface in the form of certain defenses to protect him from feeling the guilt and vulnerability of the pain.

When thoughts and concerns about me cropped up, he kept them to himself. He sensed that he even had less of a right to search for me, being the birth father. Once in the early '90s he remembers standing on the top of the Sears Tower, in Chicago, high above the clouds. He watched a lightning bolt hit a gasoline tank and watched it explode. Shortly before the explosion, he was looking out, close to where I was born, and thinking to himself that is where my baby was given up. He felt frozen in time for a moment, unable to go far into the thoughts of where I might be now. It was like not wanting to watch a fuzzy television screen for long. Two myths were very alive in the world where he was living. One, that relinquishment was to be a buried secret. Two, that the adoption was a one-time event.

These myths dissipated quickly, 33 years later, when he received a letter, wanting him to confirm his paternity to me, and requesting that he contact me, his 18th-birthday daughter. His intellect kept him cautious at first. Yet, when he realized who I was, later he would say, "Of course! You are part of me, I had nothing to fear."

He let the feelings that came up with this reconnection flow through the walls that had been built up. The guilt, and joy filled pain and relief all came to the surface. He expressed guilt in statements like, "Can you ever forgive me for letting you go?" and he confessed his insensitivity and ignorance of understanding what my birth mother had gone through.

Gratefulness came through strong in our reconnection, in knowing that the myths he had believed were not true. He did not have to keep his feelings about the pain of relinquishment buried any more, and he could see that my
relinquishment and adoption were not one-time events.

During the honeymoon of our reunion, knowing our mutual sensitivity to loss, we established a conscious commitment to each other. The need to be together surfaced more than we imagined after we first met. We took great joy in simple events and just spending time together, like others born into and kept in their birth families. In spending time together we established something that had been lost at that train station 34 years ago.

The most difficult goodbye was after the first visit. We both had allowed ourselves to prepare for the feelings because, even though the pain was great, we were finding an enormous amount of healing in all this honesty. The pain reflected the truth of our real story, the joy of our commonalities, and the merging of more family. We spent time, too, preparing for our post-reunion relationship, and setting the framework to never be disconnected again. And being a father, yes, he became protective quickly.

The gift my father has given to me, and that I hope to give back to him, is more of his truth. I want him to find the power of having more of his buried story. The chapters of being a birth father and of carrying the loss and love for his first-born have been revealed and are in the light now. I hope to reveal with him the chapters of his own relinquishment and adoption more fully, as we go forward on our journey together.
Elizabeth is a 46 year old married woman who placed a child for adoption when she was 18 years old. There has been no contact with the adoptive family since the placement. Elizabeth entered therapy in order to deal with longstanding feelings of guilt and shame related to the decision not to keep her first born son. She reported that after finding out she was pregnant, her boyfriend abandoned her and her parents put a great deal of pressure on her to place the child for adoption. Although her husband is aware that she got pregnant before she met him and placed the child for adoption, the couple never told their three children, ages 10, 13, and 15 years, about their older, half-brother. Over the years, Elizabeth has suffered from bouts of depression and self-esteem problems which she believes is related to the adoption decision. During the course of therapy, Elizabeth was encouraged to keep a journal about her thoughts and feelings related to her birth son and the decision to place him for adoption. The following are excerpts from her journal, written over the course of several months.

Dear ….. [the name she says she would have given him had she kept him],

Where do I even begin? I’ve dreamed of writing a letter like this and sending it to you. But this is only an exercise. Oh well, here goes … There are few days that go by when I don’t think about you … about my decision to surrender you … about my decision to give in to my parents’ pressure to put you up for adoption. It was such a confusing time. As soon as I told ….. that I was pregnant, he left … said he couldn’t handle being a father … just left me flat out, like he had no feelings for me or for you. Well good riddance I said then and I say it now … But it sure hurt like hell when it happened. I loved him so much and he really let me down. I think I would have kept you if he hadn’t left. But then when I think about it, I guess I don’t blame him so much … We were so young, so naive, so unprepared to raise a child. I do blame my parents though. They could have helped … they could have made it possible for me to keep you … but they were so ashamed that I got pregnant … they were more worried about what the family and their friends and the people at church would say … they never once asked me what I wanted or how I really felt … they simply told me that I must make the right decision for the baby … to place you for adoption. But really it was only the right decision for them … I realized that too late … And they made me feel so ashamed too … about getting pregnant … letting them down … And then I just gave in to them and even after all of these years, I feel so much guilt about that part too. It’s part of the reason that I’ve never been close to them ….

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… I hope you have had a good life and are happy. I hope that your parents have been loving and kind and provided well for you. I hope that my decision not to keep you hasn’t created too much pain for you, although I expect that some pain is inevitable. That’s a realization that I have to live with … and sometimes it’s hard to do …. it certainly has been painful for me …

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I have three other children, two girls and a boy, who are your half-siblings. But I must confess something that is very difficult for me. They don’t know about you. The shame and guilt I have felt have made it difficult to talk about the events that took place so long ago. Only my husband, my parents, and my sister know about the adoption … I realize that if I’m ever to be rid of my sadness and feelings of shame and guilt, I’ve got to be more open about what happened … I first have to be open with myself and then with others, including my other children … I have to be able to forgive myself … and perhaps even my parents.

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Today I told my other children about you … I cried as I did it … they were just great … they all hugged me and said that they understood … no one was angry or resentful for not being told until now. More than anything else, they wanted to know about you. But I had nothing to tell them, which only got them excited to try and find you. So that’s what we are going to do …

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We talked more about how we could find you ... but then my husband asked an important question. “What if he doesn’t want to be found? What if by finding him, we upset his life, or the life of his family?” ... It got us thinking about our needs versus your needs and the needs of your parents. So we decided not to rush into anything too quickly before we've had a chance to think it through. At the very least, though, I've decided to contact the adoption agency that placed you to see about how to search for you and if they would be willing to help

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Been feeling much less depressed recently ... more self-confident ... less guilt. Talking with the kids seems to have released some type of inner pressure in me ... secrets are terrible things ... they distort, subvert, destroy, and certainly demoralize ... Feeling so much freer now. Talked to mom the other day and told her about telling the kids about my first child. She was very upset that I told them and said that no good would come of my actions. But she’s wrong. Already there has been good ... for me, for my children, for my family as a whole. She doesn’t understand ... but that’s her issue now, not mine.
Handout #4.14  Emily

Emily is a 22 year old single woman who got pregnant during her first year of graduate study. Believing she was not prepared to raise a child, she contacted an adoption agency to make an adoption plan for her child. She indicated a desire for an open placement and eventually chose a lesbian couple, Sharon and Natalie, as the adoptive parents. The following ritual took place at the adoptive parents’ home, a week after the birth of the child. Guidelines for the ritual had been provided by a clinical social worker who consulted with the parties prior to and following the adoption. The social worker was present to help facilitate the ritual. Also present were Emily’s parents and the parents of Sharon and Natalie.

Emily [holding her child in her arms]: This is both a sad and joyous time for me … I am very sad not to be able to be a parent to Mia … to raise her and be with her all the time as she grows up … and not to be able to have my mom and dad be her grandparents like they thought they would be … but it’s just not possible … it would be selfish to try and raise her when I’m not prepared to do so … But I’m also happy too … I’m happy to have found two wonderful people to be Mia’s parents … Sharon and Natalie. So I’m here today to say to the two of you that I give you my love and my blessings and I ask you to be Mia’s parents and to help her grow up as a happy and healthy child … I am also grateful to have found two people who are willing to allow me and my parents to also be part of Mia’s life as she grows up … She will have the best of all of us. [Emily hands Mia to Sharon]

Sharon [holding Mia]: Emily, this is also a sad and joyous time for us too. In witnessing your sadness, we feel it too. And we are here to help you in any way we can … I will be forever amazed and grateful for your generosity of spirit, for your love, and for the unbelievably beautiful baby that you have bestowed on us. I only hope that we prove worthy of this cherished gift. I want to say to you today that we have not only taken Mia into our hearts, but you and your family as well. I promise you that I will do everything within my power to raise Mia with love, gentleness and empathy, and to make sure that she not only knows you, but also comes to realize our love and respect for you and your parents. [Sharon hands Mia to Natalie]

Natalie [holding Mia]: I am so overwhelmed by what is happening. I feel so much love for you Emily and I cannot adequately tell you all that is inside me … I also promise you that Mia will have a home with us that is filled with love and respect … and she will also understand that she has two families, ours and yours. That I Promise.

All the parties, including the grandparents, were asked to bring a distinctive piece of cloth, approximately 2 inches wide by 12 inches long. Emily also was asked to bring a similar piece for Mia. At this point, the social worker asked Emily’s parents to tie their two pieces together (representing the birth parents’
marital bond); next Emily was asked to tie her piece of cloth to those of her parents (representing the nuclear birth family); next, Sharon’s parents were asked to tie their pieces of cloth together, followed by Sharon tying her piece to those of her parents (representing her nuclear family); a similar process was followed for Natalie and her parents (representing her nuclear family); next Sharon and Natalie were asked to tie the pieces representing their nuclear families together (representing their joined families); finally, Emily, Sharon, and Natalie were asked to tie Mia’s piece of cloth to the ends of their respective families and to bring the other ends together forming a circle (representing the connection between the birth and adoptive families); the cloth was then passed to the social worker who asked everyone to gather together, holding a part of the circle of cloth that represented their family.

Social Worker: This circle of cloth, created by all the people here today, with love and respect for one another, represents the unbroken and eternal connection between Mia’s origins and her future, between the family that made her and the family that will raise her. She will come to know herself and be strengthened through both families.