TAC (Training for Adoption Competency)
Module #4
Clinical Issues in Providing Therapeutic Services:
Grief, Loss, and Separation
Student Make Up Assignments

Please refer to the Student Packet for Module #4 for the learning objectives for this module and the handouts. In order to “make up” Module #4, please prepare the following written materials for your teachers’ review. The assigned presentation should be scheduled with your teachers.

Assignment #1: Complete Pre-Module Assignments #4.1-#4.5 in your Student Packet. The correct answers to the quiz appear on pages 15-17 of this document. Do the quiz first and then check your answers!

Assignment #2: Develop a short essay (no longer than one page) that addresses the following questions:

• 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?
• Why might clinicians have difficulty asking about adoption?

Assignment #3: In class, participants watched 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 revealing the enormous complexities in their lives with historical background. Review a short clip from Unlocking the Heart of Adoption at http://unlockingtheheart.com/www/index.htm, review the following materials, and answer the questions that follow.

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.

Write an essay (half a page) responding to the following questions:

➢ 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?

Loss, Grief, and Separation: Adopted Children and Youth

Assignment #4: Review Handout #4.1 which describes the Kubler-Ross Stages of Grief; read the following; and answer the question that follows.

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.'

Discuss how these stages of grief may impact an adolescent in foster care for whom adoption is the permanency plan (about one page).

Assignment #5: Research the concept of “ambiguous loss” as developed by Pauline Boss. Write an essay (at least one page) that addresses the following:

- What is ambiguous loss?
- How does the concept of ambiguous loss apply in adoption? Give at least three examples.
- Why is ambiguous loss so difficult for children and youth?
- What might we see clinically when adopted children experience ambiguous loss and lack certainty in their lives?

Review Handout #4.2 which provides a glossary of adoption loss and grief terms. It is designed as a resource for you.

Assignment #6: Review Handout #4.3: Case Examples: Adopted Children’s Experience of Loss. Identify the potential losses on which your assessment might focus in each case and discuss the potential impact of these losses on the adopted child/young person (at least one paragraph for each case).

Assignment #7: 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. Choose five of the following potential losses and describe how this loss might impact a child.

- 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
Assignment #8: Look at the following that illustrates how children’s reactions to loss vary across a continuum:

<table>
<thead>
<tr>
<th>Fleeting awareness</th>
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<th>Intermittent</th>
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<th>Feelings of fragmentation</th>
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<td>of emotional</td>
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<td>periods of</td>
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<td>and emptiness &amp; intense,</td>
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<td>enduring</td>
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<td>pain</td>
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Select and discuss five of the following factors that may influence how a child reacts to loss (about one page).

- 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)
  - Taken away (anxiety and fear)
  - Caused the separation
  - 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
  - Permit/invite children to express feelings
  - Share similar experiences of other children
  - 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

Assignment #9: Based on your reading of Handout # 4.4, The Good Grief Program of Boston Medical Center: What Children Need, discuss the four psychological tasks of grief work (about half a page).

Assignment #10: Prepare a 10-minute presentation for your teacher(s) in which you discuss the following case and how you would apply the principles of grief work that follow to this case.
Andrea is a 13-year old whom Betty and Hank James adopted from foster care when she was 9 years old. Her father’s rights were involuntarily terminated while he was incarcerated for voluntary manslaughter. She had not seen him since she was 5 years old and had no contact with him while in foster care or since she was adopted. Her mother initially worked to reunify with Andrea and her two older sisters (also in foster care) but after about 6 months, began visiting less frequently and then disappeared. Her parental rights were also terminated. Andrea’s two older sisters were adopted together by their foster family, the Bakers. She has seen them rarely since they were adopted and not at all since she was adopted. Andrea has become very withdrawn and her parents think that she is depressed. They come to you for help.

Principles of Grief 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

Assignment #11: In class, participants worked on a range of clinical interventions that can be used with older children and youth. These interventions included:

Lifebooks

The Loss Box. Read the following about this intervention:

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.

W.I.S.E. Up. Read the following:

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
- **S**  Share something about my adoption story
- **E**  Educate others about adoption in general

**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
- Gives 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

**Assignment:** Read Alicia’s case (Handout #4.5) and answer the five questions that are provided (about two pages). Please do the assignment before reading the following information.

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 ever 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.

**Assignment:** Read Handout #4.6 which provides the scripted group schedule that CASE uses. Write a paragraph in which you discuss your thoughts on this intervention.
Grief and Loss: Adoptive Parents

Assignment #11: Review Handout #4.8 and for each case, identify possible losses for the adoptive parent in the case and discuss how they would assess the impact of these losses, such as the questions that you would ask (one page).

Grief and Loss: Birth Parents and Extended Birth Family Members

Assignment #12: Read Handout #4.9: Obtaining Information from Birth Parents On Physical and Psychological Contact with their Child and Disenfranchised Grief. Write an essay (about one page) addressing:

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.

Assignment #13: Read the following about disenfranchised grief and then write one or two paragraphs about you have seen or would expect to see disenfranchised grief arise in your clinical work with individuals or families (within or outside the adoption context).

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):

- 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.

**Assignment #14:** Read Handout #4.10 PACT: Stages of the Grief Process for Birth Parents and Extended Family Members and Handout #4.11 Ohio Child Welfare Training Program: Birth Parent Grief and Loss When Parental Rights are Involuntarily Terminated. Discuss the following case and the losses that this mother may experience (half a page):

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.
Assignment #15: Read the following about 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: [http://www.masspartnership.com/provider/outcomesmanagement/Outcomesfiles/Tools/BSI.pdf](http://www.masspartnership.com/provider/outcomesmanagement/Outcomesfiles/Tools/BSI.pdf)

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.

Assignment #16: Read Handout #4.12 My Birth Father's Legitimate Grief and discuss the losses that this birth father experienced (half a page).

Assignment #17: Read the following information on clinical interventions with birth parents and also read Handout #4.13 Elizabeth and Handout #4.14 Emily. Write a short essay (half a page) discussing your thoughts on using any or all of these interventions.

**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 techniques.
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)** in 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.

**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
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.

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.

Provide your teachers with the written assignments in one document and arrange a date and time for your presentation.
**Answer Key to Pre-Module Assignment #4.3 Quiz**

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.

   YES, Amy’s behaviors are possible signs of grief. Regressive behaviors and clingingness 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.