ADOPTING THE SUBJECT

Adoption is a subject that initially invites the assumption that, as it clearly has its own unique issues that distinguish it from "normal" family life, it must also produce a recognizable and distinct effect on children who are adopted. Certainly, when I first began to think about this topic, it was in relation to a couple of patients I have been working with over a long period of time, as well as some others who presented at that time, and who I worked with more briefly, who are adopted, and keenly aware of it. I became interested in particular in the therapeutic relationship, in the transference in other words, and especially in relation to how I felt I was seen and used by these people. I wondered whether there were characteristics they might have in common in this regard, and in particular whether the fact that they already had two sets of parents, the biological and the adopted, the absent and the present, influenced the transference in any common way. There were also related questions about attachment, identity formation and the possible effects of early trauma relating to separation and loss and the realisation of rejection.

I tossed around with a friend the idea of writing a paper called "Too Many Mothers, Nobody's Child", which would highlight the poignancy of how an over-abundance of actual parents resulted in the keenly felt lack of mothering (interestingly it seems to be primarily mothering, not so much fathering) that my patients presented with. This seems to have two almost opposite yet related aspects: I am at the same time seen to be both very precious, delicate and easily harmed, and yet, although it is expressed in differing, idiosyncratic, ways, I am felt to be unreal and unreachable.

Some of this I will expound on later: however I want to share some more of the thinking I have done as a way of illustrating some of the complexities of the subject, especially perhaps for me. As no doubt most of us do when thinking about our patients and their needs of us, I had to think of how I was responding, what was happening to me, what I was contributing to what was going on in the room: in other words I had to think about the counter-transference. But with an added twist. I'm aware that there is a common fantasy among therapists, even if it is one we generally try firmly to manage, that we will somehow provide a corrective mothering experience as part of the treatment and that we will therefore be better mothers than the real one (or ones) the patients have. You can imagine that in adoption, and in light of what I have indicated about the transference, that might be even more of an issue, especially because there is usually a fantasised ideal mother already existing in the patient's mind, and the therapist is obviously ripe to be cast into that role. This is of particular interest to me in these cases because I am in fact an adoptive mother.

So, in my thinking of the transference and the countertransference, no differently perhaps than I do with every case but more so, I have had to be very careful and conscious about separating my story and experience from those of my patients'. I remember some years ago being told by a child psychotherapist of the disproportionately large numbers of adoptive children she was seeing, and how I really didn't want to hear that because I

interpreted it to mean that adoption caused children to be unhappy and that was not something I wanted for my daughter. I've come to realise there are various possible interpretations in fact about that (for example, adoptive parents may be more likely to seek help than natural parents) but it made me very sensitive and I think competitive with both "natural" and other adoptive mothers. So this fantasy of being a "corrective mother" was potentially damaging to the work. I needed to be sure of my proper distance from the material and yet to remain sensitive.

I was also very sensitive to the "real" people in my patients' lives - the parents and so on. Of course, again, we all have a sense, if not a certainty, about this with all our work. What is different here was the danger I might assume I understood things about them, or project my own experiences rather than listen to those of the patient. On the other hand there is I think a possible advantage in this case to do with understanding something about the cast of characters involved in an adoption story. Every child has a mother and father story. One thing that distinguishes adoption (although there is some but not identical commonality with fostering and even with step parenting) is the number of people, real and fantasized, involved with the story. There are birth mother and father, adoptive mother and father, relinquished and adopted child (the same person) the "lost" often, idealised fantasy child of the adoptive parents and all the fairy tale figures with whom the adopted child often identifies. There are also the bureaucrats who have done the matchmaking between adoptive parents and child and who were perhaps involved with, or even partly responsible for, separating birth mother from child. There may also be "real" siblings who might or might not be adopted, as well as fantasy ones. I realised that to write about adopted people without writing about the social and cultural context would be inadequate. Children obviously come into a world and are influenced profoundly by it – there *is* no such thing as a baby!

I will spend some time looking at that, starting with how adoption is seen in myth and fantasy then going on to what the adoptive parents might have experienced. Then I'll discuss some of the people I have worked with therapeutically. Their ages range from the 20s to the 50s, and their adoption situations have varied widely so their experiences have been coloured by quite dramatically changing views and practices in regard to adoption as well as by differing family relationships. This has helped me to think about whether there is an "adoption effect" which transcends social and cultural differences. I do want to stress at this point though, that this does not mean there is any evidence about a one-to-one relationship between adoption and particular psychiatric diagnostic categories. Also, although various studies agree with the child psychotherapist I mentioned in that it does appear that child adoptees are over-represented in samples of psychiatric patients, there is no agreement that such is the case with adult adoptees. Another point: this thinking as I have said is based around adult adoptees I have worked with. The adoption situation is one in which there has been a great deal of change over many years now. For example, there are very few locally born babies now being put up for adoption and increasing numbers coming, at later ages, from other countries. There have also been legal changes in regard to an adoptee's right to know and open access adoption (where the birth mother remains in contact) which means some of the points I make might apply differently to them.

ADOPTION AND MYTH

Many analytic writers, eg Brinich (1990c) in America and Treacher (200) and Golberg (2000) in Britain have pointed out that adoption is an essential component of stories and myths as old as that of Moses, as new as that of Superman, Luke Skywalker and Harry Potter and as tragic as that of Oedipus. Adoption also plays a crucial role in many fairy tales: adoptive and stepparent relationships figure prominently in the stories of Hansel and Gretel, Snow White and the Seven Dwarves and Cinderella. It seems there is something about the adoption theme, where the abandoned orphan overcomes all manner of hardship to eventually live happily and relatedly ever after, which is universally appealing – not just to adopted children. Freud (1909) in his paper "Family Romances", written in 1909, helps identify what the appeal is. He points out that it is a commonplace event that, as the latency child begins to separate himself from his parents and become critical of them, he develops the idea that he is a stepchild or an adopted child. That is, he imagines his parents are not his parents, but surrogates or even impostors.

The fantasy of being an adoptee often moves one step further, to the idea that the child's *real* parents are nobler than those with whom he feels he has been left. Freud points out that the characteristics of the noble parents are, generally speaking, nothing more than slightly disguised versions of the child's parents *as they appeared to him in younger years.*

"Indeed," he says, "the whole effort of replacing the real father by a superior one is only an expression of the child's longing for the happy, vanished days when his father seemed to him the noblest and strongest of men and his mother the dearest and loveliest of women. He is turning away from the father he knows today to the father in whom he believed in the earlier days of his childhood; and his phantasy is no more than the expression of a regret that those happy days are gone."

Fantasies of adoption and stories of adopted or rejected children which have happy endings can help all of us deal with ambivalence, not only that of the child towards parent but also that of the parent toward child. At least, that can be the case for non-adopted children. Where the child is in fact adopted then the chance of a resolution of ambivalence toward the adopting parent may be in danger of being compromised by the reality of the existence of other parents. The fantasies about the birth or "real" parents may be of the noblest and dearest, as Freud described, and of which Superman is an example; they may be the exact opposite, imagined as cruel, callous and even incestuous or they may be some mixture for example of a Dickensian pathetic mother and rapist father. Often they all co-exist in the mind of the child.

The story of Oedipus is of course not one with a happy ending. Amongst many other things it illustrates what can happen when reality can't be tolerated, metaphorically in many respects but also literally and specifically in regards to adoption. There is not one person in the adoption situation – relinquishing parent, adopting parent, adopted child –

who is not grievously pained by at least some aspects of their experience. If that pain cannot be faced and worked through, if reality is denied then there is the risk of death, either actual or psychic.

The drunkenly conceived birth of the infant Oedipus threatened the life and status of the parents, as certainly was often, and sometimes still is, the case with relinquishing parents. They attempted to kill him, but he was spared. Adopted children may experience their rejection as a kind of murderous attack. Polybus and his wife, the adoptive parents, did not tell him the truth of his origins and he grew up believing he was their natural child. This was despite his having been taunted with the possibility that, being so aggressive while his father was so mild, he could not be his father's son. Reassurance from his adoptive parents did not allay his suspicions and he consulted the Oracle, where he was given the warning he would kill his father and marry his mother. It was because of this warning that he left Corinth in order to spare his parents, as he steadfastly believed them to be.

The action of the play describes Oedipus interrogating and blustering as he attempts to discover the murderer of Laius. As the evidence increasingly points to himself and he becomes convinced that he was not the natural born child of the Corinthian King and Queen, he is advised by the chorus that perhaps he is the "offspring of some primeval sprite" or nymph fathered by a God (which typifies the imaginings of many adopted children). Still, and at the same time despite himself, he becomes driven by a hunger to know, and he cries, "I must unlock the spirit of my birth…I ask to be no other man Than that I am, and will know who I am." (Sophocles 1947: 55) There is a moment, then, where he is able to know the ghastly truth and to feel the guilt, but it quickly turns outward to hatred towards Jocasta, his wife/mother and then to horror as he finds her hanged body, and he blinds himself, unable to bear the reality. (This interpretation is aided by John Steiner[1993]).

This inability to bear reality of course was not something particular to Oedipus, but was shared by all the protagonists. In the end everybody, including the plague-ridden citizens of Thebes, paid. The ability of Oedipus to solve the riddle of the Sphinx indicates that he had the ability to acknowledge the differences between the generations, an ability, that is, to know reality. But the patricide and mother-marriage indicate a repudiation of that reality. For this, however, he needed collaborators. What a difference it would have made had there not been so many secrets.

As we have seen, however, mere knowledge of an external reality is insufficient for psychic survival and growth. Obviously, all the adoptees I have worked with know they are adopted, (although they have varied as to their ages and means of discovery). Indeed for many years now adoption agencies have insisted that adoptive parents tell their children what they can about their origins. For beyond knowledge is truth, the understanding and integration of the knowledge and its meaning into the development of the child. In regard to external knowledge, it appears that cognitively children can begin to grasp the meaning and some of the implications of adoption at around the ages 5 to 7,

although the common wisdom now is to disclose earlier so the children will "always" have known. This is recent practice and even when I graduated from social work there was controversy about this and a social worker who was only a year or two ahead of me at university lost his job in an adoption agency because he insisted that prospective adoptive parents agree to tell their children the truth.

INFERTILITY IN SOCIETY

All of this raises the question of what the truth actually is. There is of course the hard objective reality that the adopted child was conceived and born by others, not the parents who are raising him or her. Then there is what that means to the parents, their families and friends and subsequently to the child. I mentioned that it is recent practice that agencies insist that children know as much about their conception as possible, and it is only in the last generation or so that adopted children can have as a right access to information about their birth parents. Previously it was not uncommon for adopted children to have the truth hidden from them and, when it was revealed if at all, it was perhaps because of rumours, because documents were found after the death of the adoptive parents, because someone thought the child "should" know (being either kindly or malicious, who can tell?) Being illegitimate was shameful. Being infertile was often unspeakable. And, although it is not invariably the case, it is usual that the adopting parents are indeed infertile, or believe themselves to be.

The change in practice regarding enforced openness is clear evidence of social and attitudinal change. The legal aspects of this have been deliberately based on recent understandings of every person's rights and needs to know about their history, their background and so on in order to assist them in developing a coherent sense of self. The demands of many adoptees for birth information and the openly expressed grief and often rage of relinquishing parents, who have felt they were coerced into giving up their babies, as well as the dearth of local babies being put up for adoption and the subsequent turning to other countries by prospective adoptive parents have all affected how openly infertility can be discussed. On the other hand the greatly improved medical treatments for infertility, invasive as they are, have possibly left those unable to conceive as even more marginalised than previously. In any event, there are tremendously deep and complicated feelings in relation to infertility that must be negotiated and dealt with, more or less successfully.

The longing to parent a child is a deeply felt one, and the pain of infertility runs through much of literature, in fairy stories, myths and modern drama. From Snow White's mother to the parents in the film "Artificial Intelligence", who were prepared to adopt a robot, this longing provides a continuing thread. Whether we regard parenting as primarily creative and loving or primarily as a defence against the knowledge of our own impending death, the majority of the human race wants to procreate. Whilst infertility obviously affects both men and women, it has been more discussed in relation to women. Dinora Pines (1993), in her paper on "The Emotional Aspects of Infertility and Its

Remedies" points out that "for the small girl trust in her future capacity to bear a child as her mother did is critical in the confident development of her sense of femininity, sexual identity and self esteem. These can come to fruition only when her body achieves physical maturity. Pregnancy fantasies and wishes may thus be seen as a normal part of the small girl's future identity, a goal to be achieved in her adult life." (p136)

One of the things an adopted child learns, consciously or unconsciously, is that no matter what lovely stories of being especially chosen they might be told (and sensitive children may well wonder about whether there were unchosen children and what became of them) they were not the first choice. The first choice, the couple's own biological child, was unavailable. Lacan says that the child's bond with the mother is one in which it is the object of the mother's desire. The baby is the phallus for the mother, the phallus which she realised she did not have when she was a child. For every child there is then a dismaying realisation that it is being desired not just for itself but for something the mother does not herself have. The possible implications of this with infertility are that adoptive parents are very likely to have to deal with a deep sense of failure. They may have anxieties about their sexual performance and bodily integrity, about medical investigations and the allocation of "blame", including self blame. When the cause of the infertility is not obvious they may feel this self blame even more strongly, believing they have somehow "caused" it, that they have been deemed unworthy or in need of punishment. Usually they will have to deal with a dawning and dreadful realisation over a period of perhaps years of hope and disappointment that there will be no normal pregnancy for them. There will be envy of fertile friends and a sense of difference that in my experience is not always easy for others to grasp.

I referred previously to the "Family Romance" fantasy of the better, nobler parents that a child might have. Adoptive parents must deal with their own fantasies of perfect offspring and be able to bear the narcissistic wound, to grieve the loss. One of the on-going conversations children have about growing up is about how many children *they* will have, how *their* parenting will be done (like or unlike what the child is currently getting) and so on. Just as adopted children often long for a genetic relationship, for a feeling of "being like" someone else, their parents have to come to terms with a relationship that is not based in their own biology.

This is no small task and there is no guarantee that it will be complete before the adoption process is complete. Moments of disappointment with an adopted child may be made more so by the reactivation of the fantasy of "what might have been" and anger at "what should have been". And the child may have to deal with a sense of competing with, and invariable losing to, this fantasised perfection. These moments might then reactivate the adoptive parent's sense of failure, their narcissistic wound, and the child can then be experienced as more torment than love. Unfortunately I am not convinced that even the most detailed assessments that are done today give any guarantee that this vital task of mourning the losses is sufficiently in hand, although that is one of the aims. I worked as a marital therapist a couple of years ago with a young adoptive couple, who described the assessment process they went through, a process I reacted to (perhaps in my own adoptive parent role) as being extremely intrusive. The level of disturbance I

encountered in this couple, who unfortunately came only a few times before retreating into mutual blaming and helplessness has often haunted me as I have wondered what became of their child.

I have referred to the sense of damage and failure infertile couples feel. To adopt a child they must then submit themselves to increasingly rigorous assessment procedures, which are designed, as the couples are often reminded, not to provide them with a child but to provide a child with parents. No matter how kindly and empathetically they are treated they are not seen to be the primary responsibility of the agency, but as potential service providers competing, these days at any rate, with many other potential service providers. They must submit themselves, to their friends initially, for judgement in the form of a reference and then must go through group and individual meetings over a long period of time before "passing" as suitable.

I'm going to digress from myself as professional to myself as client for a moment, to illustrate some of what infertile couples have to deal with and the judgements they silently but often ragefully have to endure. Even over twenty years ago when my husband and I started the adoption process, there were very few children available, which I suppose is one of the factors involved in the additional assessments required. One of the first phone calls I made was to a church agency which had a long established programme. I spoke to the social worker involved who, on hearing that my husband had just reached the grand old age of (I think) thirty- three, informed me we were ineligible because of that. I suppose I blurted out some shocked protest and was kindly told "That's why we try and tell people to start their families early." We were not only infertile but subject to being told how to plan our lives by a stranger. At which we had failed.

Another memory. An initial group meeting of couples inquiring about inter-country adoption, sitting in a circle and having a discussion led by a psychotherapist who, we were told, specialised in working with infertile couples. She asked who of us had told our parents we were going to be there that day (we hadn't). To those of us who hadn't told she asked us to think what it might mean about that relationship, clearly by her tone and later comments implying that what it meant was we were insufficiently open with our families. I had thought it meant we were adults capable of making inquiries without permission, but also in my case in the full knowledge that our parents would support us. It was clear that this was considered to be defensive. We felt we had failed again.

I don't want to imply that the whole process was like that and generally we were treated very well, but I want to emphasise the difficulty of the feelings involved in assessments like this and how they might promote defensiveness rather than the openness that is hoped for. Interestingly enough some years ago I was employed to assess a young couple, residents of another country, who were applying to become adoptive parents, so I do understand the demands put on workers to try and select "good" parents and I'm not insinuating that the experiences I had resulted from a lack of care by the workers. When someone is feeling damaged and sensitive it is easy to inflict more hurt.

WHAT THE CHILD MIGHT ENCOUNTER

However, usually, being accepted and then actually adopting a child does in fact repair at least some of the damage. Anecdotally it is believed that in some cases, indeed, the healing is great enough to cure the infertility and pregnancies occur. This is not supported by the latest research, as discussed in the February 02 edition of the IJP by Apferl and Keylor. Nevertheless it is a strongly held belief that adoption *can* "cure" infertility and when pregnancies follow adoption meaning will be made of it by all, including obviously the parents, the adopted child and the non-adopted child or children.

In any case, after adoption there may well be residual issues including, as I mentioned, the lack of a feeling of sameness, of connectedness at a genetic level that the children often also feel. There may be concerns about having stolen a child, of having conspired with society to deprive the birth parents of their rights, or uncertainties about still feeling different. It is clear that how we feel about ourselves colours the way we see others (something we are all so familiar with in dealing with the transference) and this is perhaps especially so in regard to how we see our children. Bonding with an adopted child can therefore be affected, and there may be difficulties with resolving ambivalence.

Every parent has to contend with disappointment as well as joy in their child, every child is at times not wanted by the parent just as every parent is at times not wanted by the child. We understand this to be normal ambivalence. Adoption can colour these normal realities for the parent because of such feelings as guilt and unresolved mourning. Either there may be defensiveness against them so the expression of normal anger and disappointment is affected, displaced, denied and so on, or the feelings may overwhelm the parent. Edward Albee, an adoptee, in his play "Who's Afraid of Virginia Woolf?"(1977) has the fantasy child of the feuding George and Martha wonder if he is adopted. However I want to emphasise again that I'm not suggesting horrendous abuse or neglect is the norm any more than in other families, simply pointing out what adoptive parents, and therefore adopted children, have to deal with, which they will in their individual ways.

There are of course other obvious differences in the parenting an adopted child gets, no matter how well resolved the issues are for the parents. Firstly, the adopting parents are not the first parents. Even when the infant is fostered out virtually from birth – and there is always a waiting period for the birth mother to consider her choices – there will usually have been some time at least of institutional care in the hospital nursery. After fostering the baby goes to the adopting parents. In other words there will be a minimum of three placements, assuming the baby is placed at a few weeks of age, which was a common practice but is no longer.

Depending on the age at which the child is adopted there might not be the experiences that are available only to parents of young infants, and therefore of course the infant would also be deprived. I am thinking for example of Bion's "reverie" or of Winnicott's primary maternal preoccupation, which he says lasts only a few weeks after the birth of the child and what it might mean to an infant to not be gazed upon with that intense and searching and dreaming gaze that features so prominently in the lives of the wanted. I

doubt that even the most competent and devoted foster family could reproduce that dreamy state. Winnicott(1992) says: “the basis for ego establishment is the sufficiency of ‘going on being’, uncut by reactions to impingement. A sufficiency of ‘going on being’ is only possible at the beginning if the mother is in this state….”(p303). Adoptive parents, even when in a close approximation of this state, may well be conscious not only of the baby that is there, but also of the baby that is not there, and of the birth parents that are not there. The scene is far more crowded.

Our thinking around very early experiences indicate other ways this “ego establishment”, this sense of self as subject, is likely to be affected by having multiple caretakers, multiple separations and therefore potentially multiple perceived losses. New neurological studies indicate that: “experience can change the mature brain, but experience during the critical periods of early childhood *organises* how the brain works.” (Perry et al, Infant Mental Health Journal, 1995). Also, “traumatic experiences in childhood increase the risk of developing a variety of neuropsychiatric symptoms in adolescence and adulthood” (Davidson and Smith, Journal of Traumatic Stress, 1990). That is, these early experiences become part of the way we are, part of who we are and of how we see ourselves.

Secondly, attachment theory, pioneered initially by John Bowlby and then by Mary Ainsworth and Mary Main, also emphasises the biological base of the need to form close affectional bonds, and the reciprocity of human relationships. That is, there develops a system of at least two people, baby and caregiver. Ideally the attachment behaviours of the infant are reciprocated by the caregiver’s adult attachment behaviours like touching, soothing and holding, which in turn strengthen the attachment behaviour of the infant to the particular adult. The activation of attachment behaviours depends on the baby’s and then the child’s evaluation of a range of signals, which results in the subjective feeling of security or insecurity. The *goal* of attachment behaviour is to experience security, which becomes a regulator of emotional experience. None of us is born with the capacity to entirely regulate our own emotional reactions, but need the caregiver to respond to changes in our emotional states, changes that can feel cataclysmic to the infant. We need someone who knows us.

The work of Ainsworth and Main allows us to think about four broad categories of attachment patterns and their implications for a sense of self and ability to relate. The *secure* infant, happily exploring when in the presence of the caregiver, anxious when separated but soon settled by being reunited, is likely to be the child of a *secure/autonomous* adult, with a sense of internal coherence, an ability to trust and develop long term friendly relationships. These caregivers remember their mothers as being generally responsible and caring and do not have constant feelings of vulnerability and loneliness.

Jeremy Holmes (1999) says “the basic problem of anxious attachment.. (is) that of maintaining attachment with a caregiver who is unpredictable or rejecting.” (p79) The *anxious/avoidant* infant seems less anxious about separation from the caregiver and may not show preference for the caregiver over a stranger. It is likely that their emotional

arousal was not restabilised by the caregiver, who may be experienced as rejecting and rigid and they therefore over-regulate their affect and avoid situations that are likely to be distressing, removing from consciousness their own neediness. They may develop into *insecure/dismissive* or *ambivalent* adults who endure love experiences based on fear of closeness and lack of trust. They idealize or devalue (or idealize *and* devalue) early nurturing relationships and may experience feelings of vulnerability or loneliness, but tend to hide these by detaching themselves from others.

Anxious/resistant (or ambivalent) infants show limited exploration and play, tend to be highly distressed by separation from the caregiver but have great difficulty settling when reunited, failing to be reassured or comforted by the caregiver. These infants under-regulate their distress possibly to elicit expectable and desired responses from the caregiver, who is felt to be inconsistent in response to the infant's signals. Parenting is likely to be both insensitive and frequently intrusive. "The ambivalent strategy involves clinging to the caregiver, often with excessive submissiveness, or adopting a role – reversal in which the caregiver is cared for, rather than vice versa. Here feelings of anger at the rejection are most conspicuously subjected to defensive exclusion" (Holmes, 1999,p79). They may develop into insecure *preoccupied* adults who tend to be confused, angry or passive in relation to attachment figures, often still complaining of childhood slights, echoing the protests of the infant. They are susceptible to loneliness and constant feelings of vulnerability and self-doubt, have multiple relationships but difficulty finding true love.

Disorganised/disoriented infants are likely to have been severely neglected or abused by the caregiver who has served as a source of both fear and reassurance. So the arousal of attachment feelings produces strong conflicting emotions and therefore *unresolved* adults give indications of significant disorganization in their attachment relationships.

All of these stories, experiences and theories, as well as many others I haven't mentioned, particularly in relation to the transmission of trauma through the generations, have influenced my thinking about my work. I want now to turn to the cases.

CLINICAL VIGNETTES

In the last two years or so I have worked with several adopted people over varying periods of time, from one session to several years. I will mention four of them. All presented with pain around a relationship, although only one came with a partner.

The first case concerned a man in his thirties, married for several years to a woman who apparently could really no longer bear him, but who he couldn't bear to let go. He acknowledged his clingy and dependent behaviour, although he felt somewhat justified in it and in its controlling aspects because he was earning a great deal more money than his wife. He seemed to feel that giving money would be the most valuable thing he could do. He was adopted by a couple who had been attempting to have a baby for some years, and who promptly conceived after his adoption, and went on to have three natural children. He was not close to any of them and had been involved in some legal disputes over a

will. He told me that the oldest of his siblings, a girl very close to him in age, used to say when they fought that he was "a bastard in every sense of the word." This appeared to describe fairly accurately how he felt about himself. He had met his birth mother but was not interested in maintaining a relationship with her, describing her as too needy of his love. At our second meeting he spent some time telling me how helpful and understanding I was, how even-handed and how both he and his wife felt they had come to the right place. I enjoyed hearing that and imagined for a moment that I did a much better job than his mother at having two voices be heard and appreciated. A few days later his wife rang and cancelled the next appointment because he couldn't make it. I did not hear from them again.

The second person I want to mention, whom I will call *O,* was a woman of thirty but seemed more like a teenager. She came for several months. She presented with an unusual story of dependence on a man who smoked a great deal of marijuana, and she experienced physical symptoms, which she thought resulted from her second-hand exposure to the drug. These symptoms seemed like fairly typical anxiety attacks, which she claimed came on after any physical contact with this man. She felt very desperately addicted to him and was very ashamed of this. She also described an addiction to "flashing" – something that I gather was far more graphic than that for which Sharon Stone was famous, and which she reserved for strangers.

This young woman came from a small country town. This was another case of an adoption preceding a pregnancy, in fact three pregnancies, all girls. She thought that the local minister, who knew both her birth parents and her adoptive parents, had arranged the adoption. She had met her birth parents who had stayed together, married and had more children several years later. She tended to speak quite pityingly of her birth mother, who she thought needed help with managing an incompetent and bad tempered husband (O's father, they had later married), and she took it upon herself to speak to him about his behaviour, which she thought had in fact helped. She felt she had to duck her birth mother's calls to a certain extent.

In her adoptive family she felt there was a clear, albeit un-named division between her and her siblings. She attributed the division to things like jealousy of her looks (beautiful) and her talent (she seemed bright but underachieving to me, but she told me often how much her employers loved her). Her parents were paying for her to see me which she thought was pretty reasonable as her mother had worked too much and neglected her as a baby. She had some terrifying memories of needing and not being able to find her mother. Of her father she spoke with contempt as a work-a-holic. Her divorced husband was described as being both distraught at her loss and someone she needed to deal with firmly because of his willingness to cheat her in the property settlement.

With me she was initially frightened and vulnerable and I found myself feeling protective and maternal. She was quite excited about coming to see me, discussing herself with great interest and emotion. She told me tearfully, angrily, about being sent away to stay with her grandmother during her mother's first pregnancy, saying she had twice lost a

mother. Then she decided to study Reiki and was particularly interested in setting up a private practice with an emphasis on the psychological side of things. It seemed at that time as if there was quite an identification developing with me. However it was soon after this, and quite abruptly, that she seemed to become distant, less touched by her experiences in the room. I found myself wanting to try harder, to convince her of my *bone fides* in regard to both my genuine interest and my competence. As this course was nearing completion she quite suddenly decided to move back to the country as her mother (her adoptive mother that is) on whom she practised her Reiki, needed her help. In what felt to me like another sudden moment she seemed to become very spiritual and develop a personal relationship with God and I had the sense she had become a partner to the holy parent so they could help her mother, now become the child. She finished her last session, pleasantly enough, but with barely a backward glance as she left.

L, a woman now in her late forties, first came to see me about six years ago. She presented with a long list of difficulties including a severe and debilitating physical illness, an abusive relationship with her employer and a marriage to a man she described as being extremely dependent on her, which she found suffocating, but whose dependence she had clearly fostered. She is the only child in the family, and angrily and contemptuously described her mother as being weak and in need of protection. Her father died shortly before her marriage at nineteen. At the end of the first session she told me as a "by the way" that she was adopted at six weeks (although it later transpired that it was closer to four months), that she had always known and it was not a problem. At one time she told me that another, wealthier family had been rejected by the agency in favour of the one that she went to. She had not sought information about her background, there didn't seem to be any point. Her husband too, was an adopted child, with a story far sadder than her own. She was a parent by the time she was twenty-one, desperate not only to know she was fertile but to have someone to look like her.

She was bright and determined and competent in presentation, and earnestly and instantly started to deal with some of the issues that she mentioned, leaving me impressed with her ability to manage and confused about why she had come. Although her answer to my question: what was she looking for? was profound and moving and apt it has been difficult at times to keep it in mind because of its very nature. Her answer? "I'm afraid of returning to non-thinking."

Non-thinking for L was in many ways equivalent to non-feeling and non-being. She functioned best when working hard, keeping at bay feelings of loss, fear, vulnerability and shame. Initially she attempted resolutely to establish a colleague-type relationship with me, terrified of needing me for anything other than "support" and it would have been easy to work on this level in a kind of pretend therapy to protect her from her wanting and her fear of wanting. Especially in the first couple of years, when threatened with the terrifying possibility of having to face her fears, which I think she felt could have precipitated a real depression, she would resort to a robotic kind of manic defence, focusing on working harder and harder, like running on a treadmill and believing she was getting somewhere.

The fear of dependency was a lifelong one. She had brought up her two loved children to be as independent as possible as soon as possible and had quit smoking not only for health reasons but in contempt of any dependency. It was soon clear from behavioural and reported changes that a strong identification was taking place with me, but this was not something she could express in words. I don't think in all our years together she has ever passed a personal remark, except to wish me a happy holiday at the beginning of a break. She certainly wouldn't dream of complaining about a break. The feeling I have had with her over and over and over is one of enormous distance. She struggles to think things through but it is just in the last couple of years that it has felt like a struggle I am in on, rather than one I witnessed and could pass judgement on. My words I think at times have felt very cold, or like blows, but she has always accepted them courteously, giving no indication of her reactions. With two in the room it has yet felt very lonely for her.

For the first few years she was almost invariably very late for sessions, blaming work commitments. However, it seemed to be more related to an inability to keep the work in mind, to keep me and her neediness in mind. Over time she has recognized that one of her major struggles has been around her contempt for vulnerability coupled with her feeling stuck with it. Then she has had to cope with the shame of having ignored her illness and therefore probably having made it worse (although she is now really pleased with her efforts to mind her health). Similarly she has protected and resented her dependent husband, desperately afraid that he would not be able to look after her when she needed him to but unable to separate herself enough from him to really know about her own needs, so tied up was she with his, wanting to protect *him* from further rejection. Even when able to recognize how she has in a way "used" him to carry her own fragility, it has taken her a long time to begin to let go. However, partly for herself and partly to show me she was working, I think, significant changes have taken place. As she gradually began to look after herself better she also began to feel something in the therapy. For example she noticed that when we were on a break she initiated because of a lengthy overseas work commitment, she was unable to remember my name, and found herself getting lost in familiar places. At another time she said that breaks for her were about a feeling of emptiness and nothingness, inside and out. In the last year or so I notice she often begins a session with reference to a previous session, or she makes links with themes that have been developing. I think she is better able to handle separation, as she now knows in her bones that we will meet again, and trusts more that I know her and will be available in our time together.

She started to become more aware of feelings about her adoption and over a longish period of time started to get involved in a search for her mother – not her father, which I think she would have felt to be a betrayal of her adored adoptive father.

She discovered her birth mother had died some years before. I was going to begin that sentence with "sadly" but it was probably a relief as the story L discovered was truly awful. Her mother had been incapable of looking after herself and the pregnancy must have been the result of some abuse, even rape. There is a great deal she still does not know about the family and the circumstances but at least for now she has stopped making inquiries and, apart from telling me recently, in response to something I said, that she had

never felt mothered, the subject has rarely been raised. This may be in part because of how she feels about her adoptive mother. On a couple of occasions when she has spoken about the search for her birth mother she has inadvertently said "adoptive mother" instead. Her adoptive mother is now unwell so it is possible that the silence won't continue for long.

The other recent development is she has been diagnosed with diabetes. This immediately preceded and I think precipitated her separating from her husband, as the need to be responsible for her own vulnerability freed her from the over responsibility she has always had to him. Despite the terror she had previously had at the thought of living alone she is relishing the freedom, whilst living a very sociable life.

I'll turn now to the last case, which is in many ways very different, but will then discuss some things that these people have in common.

E has been in therapy also for several years. She was "sent" by her husband who claimed she was suffering from a delusional jealousy, a "delusion" which turned out to be well founded. She greatly feared coming to see me, expecting to be treated very sternly. When I was gentle with her she basically fell in love with me and has remained steadfastly in that state ever since. Her husband thought her early traumatic beginnings as an adopted child might explain her insecurity and in many respects, if not entirely in regard to the jealousy, I agree with him.

E, from South East Asia, is a non-identical twin whose mother died shortly after her birth. Her father kept the other twin, a boy, and E was adopted by an infertile couple who apparently told her she was a happy smiling baby. Soon the mother became pregnant and rejected E, who was taken in by another family, very devout Catholics who had children of their own. It may be that she was taken in to replace, in some fashion, a child who would have been her age but who had died at birth. In any case, she lived with the mother of the first woman who took her in until she was in her early teens, going to her adopted family at weekends, then she went to live with them full time. There was a great deal of confusion for her about who her family actually was, until the man she thought was her grandfather explained her history when she was about seven. She describes always being treated differently to the other children and she was at times physically abused by the "grandmother" she had to look after. She has scars on arms and legs where she was beaten with sticks and burned by a cigarette. She was called Cinderella by one of the many relatives. Shamed by her father's abandonment of her she has been both enormously grateful and bitterly resentful of the family that took her in. Similarly she swings between feeling all victim and all cause. I'm not claiming by any means that this is a typical adoption scenario, but being adopted, and being rejected, is one of E's central identifying features.

She is constantly struggling to feel she belongs somewhere and constantly expecting rejection, and her life has been a repetitive series of situations where she feels she intrudes on a mother/daughter relationship, "stealing" the mother temporarily, gaining the hatred of the "real" daughter, and then losing the mother again to the real daughter. This

has been so with adoptive mother, mother-in-law, and women friends. (She has always been careful in speaking to me about her fantasies of being my favourite patient, in case it provokes the jealousy of my family too much and I have to sack her.) She broods about whether her children look like her, whether they are like her, whether they like her. When her husband literally threw her out of the house she dissociated for several days, then allowed herself to be sent back to the city where her adoptive family live, despite desperately wanting to remain here with her children and, more importantly it seemed, with me.

Since her return her therapy has been the single most important thing in her life and her relationship with me is the centre of her existence. She hangs on to every word, constantly examining them for signs of disapproval or hints that I think she should leave. She calls me her therapy mother, although saying "I know you're not my mother" as a way of keeping me happy I think, in case I don't want to be burdened by her dependence and throw her out in favour of other patients. She has been tormented by not knowing all the details of my life, even while she understands in a kind of a way, because every barrier is a reminder of her outside position. Rejection is a relentlessly on-going theme. In recent years her daughter has become very removed, refusing to allow her birthday to be celebrated by E, and claiming she was born in a cabbage patch and was adopted.

Breaks are a torment for her but have recently been helped by my allowing her to take a doll home with her. This doll, given to me by a patient after a trip to Japan some years ago, it was explained to me, is given to grieving mothers after a child dies. E has identified with it very strongly, although she doesn't know the history, not only because she thinks it looks like her as a child but because it is mine and it is small. She often picks it up and talks to it, calling it "Dolly Daydreamer" and says it is a part of her.

Being with her can be exhausting. After one session I wrote that I felt like one of Harlow's iron mothers to which the baby monkeys cling, feeling myself to be sucked dry, stuck, used and inadequate and overwhelmed by the need and the intrusive love, intrusive because of the expectation of rejection. At such times I am felt to be both the bad rejecting mother and the good adoptive mother. It's not always like that, but…

DISCUSSION

I'm confining the discussion to aspects of being in relation to adoption that are genderless and pre-Oedipal. The question of which types of defence mechanisms are being used is interesting but not in the scope of this paper. Nevertheless, there are some things to say.

The cases are different, some I know much better than others, but there are some things that seem to be held in common. Clearly, all these people strongly identify themselves as being adopted and therefore feel themselves to be different. This is not to say that feeling different is inherently pathological, but in these cases it is part of the pathology. Here, feeling different involves feeling not chosen, either by birth parents or adoptive parents – often by both. Every one has had difficulty with being in warm, accepting and mutually validating relationships, all have had difficulty with accepting vulnerability, although

they have different ways of dealing with this, ranging from narcissistic disdain and projection to a kind of wallowing in inadequacy with a search for reassurance. They all show anxious attachment patterns, with a mix of avoidant and resistant styles. There are issues in here of feeling the need to either control or be controlled by vulnerability, their own or their partner's. Related to this is a confusion about where they belong, who is really in the family and who can be trusted to stay there.

In all of them there is the feeling of not being known, and therefore of not knowing themselves and therefore of having an impaired sense of self. The struggles for the patients in these cases has been very much to find themselves, and the sense of them not having been held when they were unable to hold themselves is very strong. With the last two cases it is coupled with the fear they have both expressed of harming me, especially in the maternal transference, with their needs, and of their feelings of their needs being destructive to the other. Related to this again, I think, is the confusion I have seen between the death instinct and the life instinct, as if the death instinct is somehow the preserver. For L her inability to acknowledge her illness because of an omnipotent defence has brought her great harm. For E there is a continual love affair with the idea of dying and joining her dead mother, although she also expresses fury with her mother (and with her father) for abandoning her. Both have been affected by the knowledge that their birth was "illegitimate", as if that makes their being alive illegitimate.

In all cases, although differently expressed, there is a narcissistic kind of object relating, defined by James Fisher (1999) as one in which there is an intolerance for the reality and independent existence of the other. In this sense it is the longing for an other who is perfectly attuned and responsive and thus not a genuine other at all. True object relating, by contrast, has at its heart the allowing of the object its freedom. Fisher links this capacity for genuine intimacy with a capacity for mourning, a task vital for all the participants in the adoption story.

Not one of these problems belongs exclusively to adopted people, and there are many more difficulties I could enumerate in regard to identity formation which also are shared by others. (It is, for example, true that every parent and every child must in a sense "choose" (or reject) each other.) There is no evidence of an adoption syndrome. But there is evidence of an effect, and this points to what is needed in each case. As E sometimes says to me in her more reflective moments: "I can't keep on waiting for my family to adopt me. What I have to do is adopt myself."

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